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1.1 Introduction

The RCN Prison Nurses Forum identified that a the major areas of concern facing nurses working in prison health care is the lack of clarity about the roles and the boundaries of their practice. Therefore to get a clearer understanding the forum commissioned Colin Dale and Dr Phil Woods to undertake an in-depth research project using prison health care sites across the UK, and at all security levels.

1.2 Project aim/main objective

The aim of the project is to provide a comprehensive overview of the roles and boundaries of practice of nurses working in prison health care today.

1.3 Method

The research project was a challenging undertaking both in terms of the scope and the range of its activity. Also it needed to be realistic about what was feasible in the time-scale, and the number of stakeholders the study needed to include. The methodology used reflects this range and scope, and provides as wide and as deep an understanding of the subject area as possible.

- A systematic literature review relating to prison nursing care was conducted. This encompassed the main CD-ROM sources of medical, nursing and social sciences literature. The literature was analysed and graded against nationally agreed criteria to indicate the level of evidence contained.

- The project re-analysed a large amount of data from prison nurses who took part in the UKCC Nursing in Secure Environments project. Data was a mixture of qualitative (in the form of a Scottish prison service focus group), and quantitative (in the form of questionnaire and audit responses). It was analysed in-depth, and focused on the roles and boundaries in prison nursing.

- Observational case studies were conducted on three health centres in the England and Wales prison service that provide the main types of prison health care: a day service with a visiting GP and an in-patient service. The anonymised case studies were based on the structured observations and include data on the structure and format of the service. These focused on the role, function and boundaries of practice of the nurses working in the centres.

- To reflect the UK's three separate prison services (England and Wales; Scotland; and Northern Ireland) focus groups were held with a sample of nurses Northern Ireland and Scotland. The focus group for Scotland hit a number of logistical difficulties and it was not possible to hold it in the available time scale. Fortunately the study team had access to the original focus group material generated during the UKCC secure environments project, which it re-analysed.

- Consensus conferences: Results from the systematic literature review, analysis of existing data, case studies, and focus groups were presented to prison nurses and attendees at the RCN prison nurses' conference in May 2001 and RCN Congress in May 2001. Their critical comment and feedback helped to shape this final report.

1.4 Summary of findings

- 178 references were identified from the electronic databases. A small number of descriptive studies could be classified as non-specific reviews and non-controlled studies. However, the vast majority of the

literature was opinion-based descriptions of services and initiatives. This provided useful background information but an unreliable source of firm views or findings.

- The analysis of the demographic data from staff questionnaire respondents indicated that the profile of respondents in health centre one was very different to health centres two and three. They tended to be older and qualified for longer, and appeared less able to access professional literature and support.

- Competency data relating to role revealed:

  - Responses about the role of nurses working in prisons suggested that while the great majority of respondents saw the competencies as important aspects of care, some of the competencies did not form part of their current role.
  - Differences emerged in the overall results between the health centres. In general respondents from health centre one reported higher levels of supervisory activity in their jobs than respondents from health centres two and three. This was made quite clear in responses about both being part of their own role as well as being 'responsible for ensuring others undertake this'.
  - Also health centre one respondents generally reported less involvement in psychosocial aspects of care than the other two health centres.
  - Across all three health centres discharge and community support gave the poorest response from nurses questioned. The majority did not identify discharge and community support as a part of their nursing competencies and role. While there was greater identification with raising of awareness of discharged prisoners' needs, the promotion of individuals' needs, involvement with placements and discharge packages, were not generally considered to be a part of the nursing role.
  - Many respondents did not consider security as an aspect of the nursing role. This may reflect nurses' low level of involvement in security procedures in some prisons and the limited contact that they may have with prisoners' friends and families.
  - However, respondents from all three health centres placed a strong emphasis on professional development, although very few thought this was a part of their role.

- Competency rating data revealed:

  - The rating of competencies as either important or very important ranged from a low of 87.2 per cent through to a high of 98.3 per cent. This was consistent across all three health centres, with only minimal differences evident between them. Of the 45 competencies the vast majority were considered as either important or very important by over 90 per cent of respondents in all three health centres. It can be concluded, therefore, that there was very strong support from the vast majority of nurses in all types of health centres for the importance of the competencies.

  - When considering the role of nurses in prison health care two aspects of their role appear to take precedence:
    - the problems of providing care in a secure environment where the primary purpose is not health care
    - the nursing role is more about breadth than depth.

- Nurses unanimously said that the factors that made their work in the prison service work different were:
  - the problems of getting used to the security procedures
  - the security procedures took precedence over all other considerations, including health care at times.

- Nurses found the physical security of the environment often overwhelming and at times intimidating.

- Nurses often commented that the unique culture of the prison environment was not well suited to the values and aspirations of professional nursing practice.

- Prison nursing is different, or special, because of its setting and the expectations of the nursing role to meet the health needs of the prison population. This demands a tremendous breadth of knowledge that often encompasses all four elements of professional nursing.

- The key elements identified in this study that shape of the role of prison nurses are:

    - in-patient care
    - primary and out-patient care
    - prison community nursing
    - health promotion
    - liaison with external agencies
    - reception and screening
    - emergency nursing and crisis care.

- Data suggests that there are two significant boundary areas:

1. the boundaries of practice between the various grades of nurses and the tasks they are asked to undertake
2. the boundaries of practice between professional health groups, and in particular between nursing and medical staff.

- It was evident from the case study and focus group data that some sub-specialism exists, particularly among the larger nursing teams in health centre three services. Often staff were rotated through various teams and activities, matching their skills to activities and where possible.

- There was widespread support for the broader introduction of nurse prescribing.

1.5 Recommendations

1. The literature search should be extended to hand searching key journals to ensure that no significant material has been missed.

2. Ways of reducing risk should be developed that use accurate assessment material including all known information on prisoners who are likely to be at risk in the first hours/days in prison.

3. A more comprehensive health check should follow the initial reception screening that includes a mental health assessment.

4. Comprehensive care plans should be developed for prison settings that are based on individual needs assessments.

5. The appropriateness of delivering more prison-based community care or hospital day care facilities should be explored. Better support for nurses who deliver this type of care should also be examined.

6. Mechanisms should be explored to provide ways of supporting nurse triage.

7. Specialist services and appropriate training with links to the local NHS should be set up to provide health care for health conditions that occur frequently in the prison population.

8. To keep in step with the radical changes taking place in the NHS the prison service should embrace NHS Plan concepts and develop nursing practice accordingly. The 10 key roles proposed by the Chief Nursing Officer offer an opportunity to consider how to develop advanced practice, and how to reflect this in a clinical career structure.

9. Consideration should be given to the wider introduction of nurse prescribing.

2 Introduction

The RCN Prison Nurses Forum identified that a major area of concern facing nurses working in prison health care today is the lack of clarity about the roles and the boundaries of their practice. Therefore to get a clearer understanding the forum commissioned an in-depth research project using prison health care sites across the UK, and at all security levels.

3 Background and context

In the UK there are three prison services: (1) England and Wales; (2) Scotland; (3) Northern Ireland. Each has developed to reflect the needs of their different populations. Each service has made strategic decisions to provide health care that echoes what is provided in the wider community, and they rely on registered nurses as the main resource for health care provision.

Over time health care provision in each service has moved from being provided by prison officers with prison service training, to the development of strategies that increase the involvement of registered nurses. In examining the three services, however, there are major differences in how this has been approached.

3.1 Health care provision in prisons

The size of the prison population has historically depended on the attitudes of the government of the day and society. In England and Wales it has risen steadily over the past four decades to 61,620 (December 2000). In Scotland the population is 6,118 (March 2001). The 1,179 prisoners in Northern Ireland (average figure for 1999/2000) reflect a reduction following recent political initiatives and the closure of the Maze prison (see Table 1).

	Prisons	Population
England and Wales	135	61,620
Scotland	17	6,118
Northern Ireland	3	1,179

Table 1: Prisons and prisoners in the UK prison services

The level of health care provided in each of the prisons varies but can be generalised as:

Health care centre 1 - daytime cover, generally by part-time staff
Health care centre 2 - daytime cover, generally by full-time staff
Health care centre 3 - in-patient facilities with 24-hour nurse cover
Health care centre 4 - as for type 3 but also serves as a national or regional assessment centre

In the prison service the governor is primarily responsible for the prison health care centre and line manages the staff who work there. As part of the general thrust of devolution of management responsibility that the service has seen in the last few years, governors are not obliged to follow any one particular model. Therefore the organisation of any one type of health care centre varies both in management, staffing mix and number.

3.2 The Northern Ireland prison service

The Northern Ireland prison service currently has three prisons that saw an average 1,179 prisoners held during 1999/2000:

- HMP Maghaberry – a high security prison housing male long-term and unconvicted prisoners and all female prisoners
- HMP Magilligan – a medium security prison housing shorter-term adult male prisoners that also has low security accommodation for selected prisoners nearing the end of their sentence
- HM Young Offenders Centre – a young offenders centre for male remand and sentenced young offenders.

The Prison Service College at Millisle in Co.Down is the staff training facility.

All three prisons have in-patient facilities and 24 hour health care.

Prison	24 hour health care	In-patient facility
HMP Maghaberry	√	√
HMP Magilligan	√	√
HM Young Offenders Centre	√	√

Table 2: Prison health centres: Northern Ireland

The last year has been one of considerable change and upheaval for the Northern Ireland prison service. There has been the continual release of prisoners under the Northern Ireland (Sentences) Act 1998, and the closure of the Maze prison, both of which have led to a reduction in staff numbers.

The voluntary staff reduction programme has dominated the human resource agenda recently. By the end of March 2000 210 staff had left the service under the early retirement/severance scheme, and the number is expected to reach around 1,100 before the scheme closed on 31 March 2001.

Full-time and part-time medical officers, supported by nurse officers and health care officers provide primary and mental health care services for prisoners. Secondary care is provided through the health care trusts. The aim of the Northern Ireland Prison Service is to provide a level of health care equivalent to what is available in the community. During 1999 18 nurse officers were recruited together with a principal nurse officer. An additional seven nurse officers began their initial training towards the end of 1999, with a further 22 nurse officers were recruited in the summer of 2000.

The staffing changes brought around by the closure of the Maze prison have meant that the ratio of qualified nursing staff has increased in the service. This has also resulted in nursing staff undertaking six of the nine prison officer training modules. Nurses are now qualified to take on duties that they previously were prohibited from doing and do not always now require the presence or assistance of prison officers.

One of the key objectives of the service has been the promotion of vocational programmes in key areas such as health care.

3.3 The Scottish prison service

By 23 March 2001 there were 6,118 people in Scotland's prisons. Following a number of closures and amalgamations there are now 17 prisons, which include the private prison at Kilmarnock and HMP Zeist in the Netherlands. These range in size from Barlinnie in Glasgow with over 900 places, to Inverness with 108 and Zeist with six. Most house adult male prisoners. One is solely for young offenders, while three other prisons also have young offenders institutions. There are two open prisons at Castle Huntly and Noranside. Cornton Vale near Stirling is the main women's prison. A number of prisons are well over 100 years old. Kilmarnock is the newest prison with 500 places, which was opened in March 1999. It was designed, constructed, managed and financed by the private sector. Longriggend held remand prisoners under the age of 21, and Dungavel, which held category C prisoners, closed in April and July 2000 respectively.

Type of health centre	Number	Per cent
GP 9 to 5	4	23.5
7am to 8pm	7	41.2
In-patient facility	6	35.3
Total	17	100.0

Table 3: Prison health centres: Scotland

The Scottish prison service aims to give all prisoners primary medical treatment comparable with care in the outside community. Medical services are usually provided by local general practitioners, while visiting consultant psychiatrists provides psychiatric services. The Scottish prison service has developed its own psychology service, as well as drawing on external psychologists. Dental treatment is also provided. Table 3 provides a summary of the types of health centre facilities provided by the Scottish prison service.

Pregnant female prisoners receive pre and post-natal care both in prison and at the local maternity hospitals where births usually take place. At the discretion of the governor new mothers are allowed to keep their babies with them in prison until the child is one-year-old. Mother and baby cells are provided at Cornton Vale together with items necessary for the care of a baby.

For some years the Scottish prison service has exclusively employed nursing staff for its health centres and does not employ health care officers. The service believes that this enables them to focus on the development of the service and its personnel, without distracting debate on the conflicting roles and responsibilities of different staff groups.

3.4 The prison service in England and Wales

With the size and scope of its service the prison service in England and Wales presents the most diverse and complex challenge in the delivery of services, particularly in relation to the consistency of care across the service. There are 135 prisons in England and Wales, and at the end of December 2000 there was a total prison population of 61,620 (HM Prison Service and NHS Executive, 2000. www.homeoffice.gov.uk/rds/pdfs/prisdec00.pdf). Approximately 50 per cent of health centres have in-patient facilities with the remainder equally distributed between health centres of types one and two (see Table 4).

Type of health centre	Number	Per cent
GP 9 to 5	36	26.6
7am to 8pm	32	23.7
In-patient facility	68	49.7
Total	135	100.0

Table 4: Prison health centres: England and Wales

Care staff in the health centres are divided between nursing staff and health care officers:

- 1,405 nursing staff make up 57.4 per cent of all care staff
- 1,041 health care officers make up 42.6 per cent of all care staff.

Some health care officers are also registered nurses. (See Table 5).

Nurse qualified staff		Health care officers	
RGN	816	**Principal officer**	49
EN (G)	100	**Senior officers**	161
RMN	399	**Health care officers**	543
EN (M)	34	**Health care officers with nurse registration**	288
RNMH	31		
EN (MH)	13		
MIDWIVES	12		
TOTAL	**1405**	**TOTAL**	**1041**

Table 5: HM prison service for England and Wales: care staff (1998/1999 figures)

This mix of care staff has created difficulties and divisions over the years. The strategic direction for prison health care over the past decade has been the recruitment of nursing staff to replace health care officers with the offer of conversion training for health care officers to nurse registration.

This policy is now under some doubt since the announcement by the prisons minister to recruit of health care officers again in an attempt to address the nursing shortages in the prison service. Clearly this will have a significant impact on the role of the nurse in this service.

3.5 Health needs of prisoners

A recent government working party was formed to consider the role of nurses and health care officers in the prison service for England and Wales (HM Prison Service and NHS Executive, 2000). It suggested that health needs assessments should provide a means of identifying the occupational standards so that health care teams could deliver an appropriate service. Current data, however, is unable to match to either skills or resources.

Ten per cent of the prison population report sick each day (Wool, 1993), a rate some eight times higher than the attendance rate of people at their GP surgeries. Since 95 per cent of the prison population is under 50 years of age, it has been suggested that this is more likely to be the result of more general problems such as the inability of some vulnerable prisoners to cope with prison life (Acheson, 1993. Also prisoners cannot buy ordinary household remedies such as aspirin, and this has led officials to suspect that prisoners exaggerate or manipulate symptoms to get drugs or medicines(Walsh, 1998).

In some prisons health care is provided through contractual arrangements with third party providers, particularly in privately managed prisons. However, there remains considerable variation in the organisation, delivery, quality, funding, effectiveness and links with the NHS. This situation is largely a product of a historic legacy, ad hoc development, and relative isolation from the NHS (HM Prison Service and NHS Executive, 1999).

About two-thirds of the consultations with inmates involve contact with a nurse or a health care officer, 27 per cent with a prison doctor and 9 per cent with a visiting NHS specialist (HM Prison Service and NHS Executive, 1999). The prison population is predominantly male and contains a high proportion of heavy drinkers and smokers.

Recent reports have identified the that most common health problems of prisoners are:

- self harm
- diabetes
- asthma
- communicable diseases
- drug addiction (UKCC and University of Central Lancashire, 1999).

Other authors (Rodriguez, 1994) suggest that health problems inside prisons are similar to those in the community except that they are in a higher proportion than would be expected in people of the same age group. The problems common to marginalised groups such as infectious and sexually-transmitted diseases, HIV infection and AIDS are also prevalent in the prison population (Weild *et al.,* 1998).

Prisoners have higher than average rates of mental illness (Gunn *et al*., 1991). The most common type of disorder are:

- psychosis
- substance misuse
- paranoid and borderline personality disorders.

The Office for National Statistics' study *Psychiatric morbidity among prisoners in England and Wales* (Singleton et al, 1998) identified that between 39 per cent of male prisoners to 75 per cent of female remand prisoners suffer significant neurotic symptoms such as anxiety, depression, and phobias. When compared to incidence of neurotic symptoms in the general population where 12 per cent of men suffer and 18 per cent of women, it is clear that prisoners have increased incidence of mental ill health. Increased rates of alcohol abuse and drug dependence in the year prior to coming into prison were also found to be significantly higher than those in the general population.

3.6 Young offenders

In the UK children and young people make up a quarter of all known offenders, and they are also among those likely to have health problems. Recent studies indicate that children and young people suffering from poor health, including those with mental health problems, were more likely to get drawn into crime than their peers (NACRO, 1998). Factors that indicate whether a young person is at risk of offending overlap with those that influence young people to adopt unhealthy lifestyles (NACRO, 1998).

A 1997 survey by the Prisons Inspectorate found that a quarter of young prisoners were homeless on reception into prison (Cavadino, 1999). Local authority care featured in many of the prisoner histories. Twenty-six per cent of all prisoners and 38 per cent of prisoners under 21 had been in the care of the local authority. This compares with 2 per cent in the general population.

3.7 Occupational standards

In 1998 the Custodial Care National Training Organisation (CCNTO) was set up by major employers in the prison sector. It became recognised by government as the body responsible for national occupational standards including National and Scottish Vocational Qualifications (NVQs and SVQs). CCNTO's responsibilities cover the prison services in England and Wales, Scotland, and Northern Ireland, private sector prisons, the juvenile secure estate, court and escort services, electronic monitoring, immigration detention centres, military corrections, police custody, related voluntary sector organisations, and special and state hospitals. CCNTO has recently developed national occupational standards, NVQs and SVQs at levels 2 and 3 for operational staff.

CCNTO is now working to complete a framework of standards across the whole range of staff groups, and is taking this work forward through a project with three strands including custodial health care. The project has now reached the stage where draft standards and proposals for qualifications have been developed and are being consulted on. The titles of the health units for consultation are:

1. screen individuals' health and wellbeing on reception into custody
2. support inter-disciplinary teams in delivering individualised programmes of care
3. prepare and undertake agreed clinical activities with individuals
4. administer and monitor medication for individuals consistent with protocols, standards and legislation
5. support individuals when they are distressed
6. establish, sustain and disengage from relationships with individuals
7. contribute to the security of the custodial environment
8. contribute to raising awareness of health issues
9. enable individuals to address issues which affect their health and social wellbeing
10. plan, implement, monitor and review programmes of care for individuals
11. assess the health needs of individuals who report specific issues with their health and wellbeing and make any necessary referrals
12. support individuals during clinical activities
13. support individuals in undertaking health care
14. contribute to the prevention and management of abusive and aggressive behaviour
15. contribute to the protection of individuals from abuse
16. promote the health of individuals who are subject to the physical management of violent behaviour
17. maintain restrictions on individual's liberty while promoting and protecting their rights
18. develop one's own knowledge and practice
19. contribute to the development of the knowledge and practice of others
20. support and challenge workers on specific aspects of their practice
21. develop and sustain effective working relationships with staff in other agencies
22. promote communication with others through the use of interpreting services
23. support individuals experiencing a change in their care requirements and provision.

The recent working party on the role of nurses and health care officers in the prison service for England and Wales (HM Prison Service and NHS Executive, 2000) suggested that core occupational standards should be based on those identified by the *Nursing in secure environments* report (UKCC and the University of Central Lancashire, 1999). These occupational standards are:

- safety and security
- assessment and observation, including risk assessment, and risk management to reduce self-harm
- management of violence and aggression
- therapies and treatments, including cognitive behaviour therapy and psycho- social support
- knowledge of offending behaviour and appropriate legislation
- report writing
- jail craft - a term used to describe the prison context and culture
- practical nursing skills
- first aid
- administration and management of medicines.

These essential occupational standards cut across the traditional training of registered general and mental health nurses, health care officers and practice nurses. However, the working party also considers these

standards to be essential for all staff working in prison nursing (that is both registered nurses and non-registered staff). This would ensure the development of a competent workforce that is safe to practice.

Other occupational standards may include:

- knowledge of substance misuse
- IT
- communication skills
- understanding the ethnic and cultural aspects of care.

3.8 Nursing care in prisons

Providing nursing care in prison requires staff with considerable expertise in both personal and professional skills. Currently significant confusion exists about the specific skills needed to practice nursing in the prison service, as well as issues around role ambiguity and particularly role overlap with health care officers (HM Prison Service and NHS Executive, 2000). In order to ensure that this expertise is developed and maintained for nursing staff, considerable continuing professional development, coaching and supervision will be required (UKCC and University of Central Lancashire, 1999).

There are shortages of all key professionals working in prison health care including nursing staff, and for many training in the care of patients is inadequate (UKCC and University of Central Lancashire, 1999).

There is an emerging need for staff skills to be made explicit to prison health care provision throughout the criminal justice system in the UK.

A number of issues have been highlighted, such as the need to:

- build specialisation on a general base of occupational competence
- guarantee that individual competence is being maintained and developed
- assist career development for staff working in prison health care
- update to meet current and future organisational needs
- retain and improve motivation, morale, effectiveness and efficiency.

It is likely that these issues will mean that many prison health care workers will have to maintain and extend their existing skills. They may also have to learn new skills in order to respond to organisational changes. In other words it is likely that by exploring and developing nursing practice it will be possible to embrace the development of performance capabilities, both in breadth and in depth.

In the recent review of prison nursing (HM Prison Service and NHS Executive, 2000) it was stated that prison health care services must "make best use of the skills currently available and those that are likely to be available in the future", and also make more "flexible use of staff and modular competency-based training".

All these initiatives should be linked to assessing patient need, occupational standards, clinical governance, work patterns and reward. They must take into account the special nature of the prison setting, the variation in prison populations and the high rate of prisoner movement between prisons (HM Prison Service and NHS Executive, 2000). Prisons and health authorities have been asked to complete a joint health care needs assessment and agree a time-tabled joint prison health plan by March 2001. Models for developing skills and competencies for health care staff should be based on the findings of the health needs assessments.

The government is keen to see the development of flexible career paths and progression for nurses. This should be based on the identified needs of the service, the individual's assessed competency and ability to take on more complex or more specialised service roles, or management roles (HM Prison Service and NHS Executive, 2000). As part of this nurses are likely to be asked to take modules in custodial care including certain health care and nursing modules that are relevant to prison health care, which they may not have previously studied such as mental health.

This view reflects some of the complexity and diversity of the nursing and health care role in a prison environment that requires competencies that are evolving. Prison health care not only includes meeting physical, mental health and the learning disability needs of clients, but must also be delivered in an environment that requires compliance with rigorous security policies and protocols.

In the prison service there is friction between the interests of the prisoner and the health and social care of society, and nurses are sometimes asked to justify their actions. But it is important for nurses to practice within the UKCC Code of Conduct, and to safeguard the interests and wellbeing of patients. Registered nurses need to improve and maintain their professional knowledge and competence, as well as acknowledge any limitations. They also need to know how to collaborate and co-operate with other health and social care professionals in the multi-professional, multi-agency environment that they work in.

Prisons are extremely challenging environments to work in and test moral and ethical work practices. Some staff may feel unable to participate in particular programmes and activities such as child abuse, and may claim this as a form of conscientious objection. Confidentiality is also a sensitive issue in prisons, particularly with the vulnerability of the group being cared for. The media have a serious interest in the work of these organisations, and staff feel the additional pressure of ensuring that no information held by them finds its way into the public arena.

4 Project aim/main objective

The aim of the project was to provide a comprehensive overview of the roles and practice boundaries for nurses working in prison health care at all levels of security, and across the UK.

5 Methodology for the study

The research project was a challenging undertaking both in terms of the scope and the range of its activity. Also it needed to be realistic about what was feasible in the time-scale, and the number of stakeholders the study needed to include.

To achieve as wide and as deep an understanding of the subject area as possible the report authors used a mix of observational case studies of three prison service health centres, an in-depth re-analysis of existing data, focus groups and a literature search.

The methods adopted were as follows:

5.1 A systematic literature review

A systematic review of the literature relating to prison nursing care encompassed the main electronic sources of medical, nursing and social sciences literature.

The search terms nurs* near6 (prison* or correction*) were used to search the following electronic databases: CINAHL (1982-2000); Psychinfo (1984-Nov 2000); Medline (1987- Dec week 4 2000); Mental Health Collection (1995-Dec 2000); Nursing Collection (1995-Dec 2000); Nursing Collection 2 (1996-Dec 2000); HMIC; British Nursing Index (-Sept 2000); RCN Journals (1985-1996); Embase (1984-Dec 2000).

All references were entered into Reference Manager and non-relevant and duplicate entries removed.

The literature identified was graded using the Clinical Standards Advisory Group (Cochrane Initiative) scheme. This system describes literature at four levels:

1. systematic Reviews (SR)
2. randomised Controlled Trials (RCT)
3. non-specific reviews - other studies (OR)
4. non-controlled studies etc - other studies (OS).

This was the approach taken in the scoping and literature review undertaken for the UKCC by the Royal College of Nursing Institute into the nursing, midwifery and health visiting contribution to the continuing care of people with mental health problems (UKCC, 2000).

A randomised controlled trial (RCT) was used to achieve the best standards of research and the most robust evidence of the effectiveness of nursing care. Other experimental models, observational studies and expert opinion produce less sound results, and were only used when good quality RCT evidence was not available. The report authors also used evidence-based practice, specifically in relation to psychiatry, in conjunction with any scientific evidence (Elliot *et al.*, 1995).

5.2 Analysis of existing data

The policy framework for the UK prison services was examined and the implications for the role and function of nursing were highlighted.

The project re-analysed data from prison nurses that was captured as part of the UKCC Nursing in Secure Environments project. The data was made up of qualitative information from a Scottish prison service focus

group, and quantitative data from questionnaire and audit responses. Data from the secure environments project was subjected to a more in-depth analysis that focused on the roles and boundaries in prison nursing.

5.3 Case studies

Observational case studies took place at three prison health centres in England and Wales that provide the main types of health care service:

- day service with a visiting GP
- in-patient service.

Anonymised case studies were based on the structured observations of author Colin Dale and include data on the structure and format of the service. These focused specifically on the role, function and practice boundaries of the nurses working in the centres.

5.4 Focus groups

It was critical that the study reflected the three UK prison services:

1. England and Wales
2. Scotland
3. Northern Ireland.

Although the three services have a lot in common, the project set out to identify their unique features and their impact on the nursing role. To achieve this a focus group was held with a sample of nurses in Northern Ireland and also Scotland. However, the focus group for Scotland hit a number of logistical difficulties and it was not possible to hold it in the available time-scale.

Fortunately the study team had the original focus group material from the UKCC secure environments project, and it was possible to re-analyse this for the project.

5.5 Consensus conferences

Results from the systematic literature review, analysis of existing data, case studies, and focus groups were presented to delegates at the RCN prison nurses' conference and RCN Congress in May 2001. The critical comment and feedback from prison nurses and delegates helped to shape this final report.

6 Results

6.1 Systematic literature review

Using the search terms outlined in Section 0, and after the removal of non-relevant and duplicate entries, 178 references were identified from the electronic databases. These are listed in Section 0.

Most of the literature reviewed revealed opinion-based descriptions of services and initiatives, which provided useful background-only information (see Section 0). The review also identified a small number of descriptive studies under the headings:

- non-specific reviews
- non-controlled studies.

The literature proved a valuable addition to the study. It provided ideas and themes to help inform and clarify some of the discussion section. The literature was predominantly anecdotal, and was not considered rigorous enough to be used as evidence in the context of the current Government project such as the Cochrane initiative and the National Institute for Clinical Excellence (NICE).

A possible further use of the literature search would be to hand search some key journals to ensure that no significant material had been missed.

6.2 Re-analysis of the UKCC secure environments prison nursing data

Two main data sets were subjected to further analysis. They consisted of a staff questionnaire and the audit results from an evaluation of nine prison health centres.

6.2.1 The staff questionnaire

The questionnaire was divided into two parts. The first section asked respondents 15 questions about the following subjects:

- type of organisation in which they work
- the age band of patients
- gender of patients
- job title
- the country in which they work
- their age
- professional qualifications
- education
- professional development.

The second part of the questionnaire dealt with nursing competencies.

The total number of prison nurse respondents was n=435: health centre 1 (n=30); health centre 2 (n=65); and health centre 3 (n=340).

6.2.2 Demographic information

The staff questionnaire posed a number of background questions about respondents' jobs. Analysis revealed some differences between the demographic profile of the three types of health centre.

6.2.2.1 The prisoners receiving care

The gender of prisoners reflected the gender balance in the general population. However, respondents reported differences in the profile of health centres, including that health centre one had no mixed facilities (see Table 6).

	Health centre 1		Health centre 2		Health centre 3	
	N	%	N	%	N	%
Male	27	90.0	54	83.1	266	78.2
Female	3	10.0	4	6.2	40	11.8
Both			7	10.8	34	10.0

Table 6: Gender of patient group

The age groups of the prisoners also indicted some differences between the health centres (see Table 7). Health centres one and two had higher levels of adult only populations (73.3 per cent and 67.7 per cent respectively) in comparison to health centre three (59.4 per cent).

	Health centre 1		Health centre 2		Health centre 3	
Age band	**N**	**%**	**N**	**%**	**N**	**%**
Under 16	1	3.3	1	1.5	5	1.5
Over 18	22	73.3	44	67.7	202	59.4
Under 16 & 16 to 18			2	3.1	7	2.1
16 to 18 & over 18	2	6.7	3	4.6	61	17.9
All ages	5	16.7	15	23.1	62	18.2
Unknown					3	0.9

Table 7: Age band of patient group

6.2.2.2 Country of origin of respondents

Responses were received from all four UK countries. The analysis of the respondents shows some under-representation of respondents from health centres one and two, given the overall figures for this group (see Table 8).

	Health centre 1		Health centre 2		Health centre 3	
Country	**N**	**%**	**N**	**%**	**N**	**%**
England	27	90.0	44	67.7	250	73.5
Scotland	1	3.3	21	32.3	68	20.0
Wales	2	6.7			10	2.9
Northern Ireland					12	3.5

Table 8: Country of origin

6.2.2.3 Job titles and grades

Details of the job title analysis by health centre are in Table 9. Staff nurse was the most frequently reported job title at all three health centres. Although there were many more staff nurses reported working in health centres two and three (66.2 per cent and 65 per cent respectively) than in health centre one (46.7 per cent). However, this difference resulted from to the number of respondents in health centre one who reported that their job titles were charge nurse or health centre manager. Twenty per cent of health centre one respondents had charge nurse as a job title, compared to 3.1 per cent in health centre two and 5.6 per cent in health centre three. Twenty per cent of health centre one nurses reported health centre manager as their job title. While in health centre two it was 6.2 per cent, and in health centre three the figure was 5.6 per cent. It is believed that the reason for this could be that health centre one services tend to have smaller numbers of nursing staff who often work more autonomously. The greater percentages of charge nurses and health centre managers probably reflects the higher concentration of senior staff in these centres.

	Health centre 1		**Health centre 2**		**Health centre 3**	
Job Title	**N**	**%**	**N**	**%**	**N**	**%**
Staff nurse	14	46.7	43	66.2	221	65.0
Enrolled nurse	1	3.3	3	4.6	9	2.6
Senior nurse			1	1.5	6	1.8
Team leader					3	0.9
Charge nurse	6	20.0	2	3.1	19	5.6
Clinical nurse specialist	1	3.3	1	1.5	8	2.4
Health care officer	2	6.7	11	16.9	55	16.2
Health care manager	6	20.0	4	6.2	19	5.6

Table 9: Job title

Fewer health care officers were among respondents from health centre one (6.7 per cent) in comparison to health centre two (16.9 per cent) and health centre three (16.2 per cent). This may reflect the need to have staff with a broader range of nursing skills when numbers are small and the role demands are more diverse.

Other job titles such as senior nurse and clinical nurse specialist were reported in small numbers in all three health centres. Team leader was only reported by health centre three respondents.

Surprisingly few respondents reported enrolled nurse as their job title. This was confirmed by cross-referencing to data on the nursing qualifications of respondents. Although significant strides have been made in recent years to encourage enrolled nurses to undertake conversion training to first level nurse registration, there are still many enrolled nurses employed in the prison health services. Therefore the low numbers of enrolled nurses in all three health is difficult to explain.

6.2.2.4 Job grades of respondents

The analysis of job grades highlighted a number of differences between the three health centres (see Table 10). Some of the results can be usefully cross-referenced with job titles (see Table 11).

	Health centre 1		Health centre 2		Health centre 3	
Grade	**N**	**%**	**N**	**%**	**N**	**%**
C			1	1.5	4	1.2
D	3	10.0	2	3.1	29	8.5
E	14	46.7	32	49.2	150	44.1
F	7	23.3	2	3.1	24	7.1
G	1	3.3			9	2.6
H	1	3.3			5	1.5
Practitioner nurse			13	20.0	46	13.5
Clinical supervisor			1	1.5	6	1.8
Health centre manager	2	6.7	2	3.1	13	3.8
Health care officer	1	3.3	10	15.4	39	11.5
Senior health care officer	1	3.3	2	3.1	14	4.1
Principal health care officer					1	0.3

Table 10: Grade

The most common clinical grade of respondents was grade E, with respondents from all three health centres reporting similar levels (between 44 and 47 per cent). Respondents at grade D ranged from 3.1 per cent in health centre two to 10 per cent in health centre one. However, the numbers were generally small and the more usual grade for staff nurse was grade E.

There were much high numbers of grade F nurses in responses from health centre one (23.3 per cent) than in either health centre two (3.1 per cent) or health centre three (7.1 per cent). This probably reflects the higher levels of charge nurse and health centre manager job titles from the respondents from health centre one. G grade nurses were reported at very low levels in all health centres (3.3 per cent in health centre one; 1.5 per cent in health centre three; and not at all in health centre two). Therefore it must be assumed that the usual grading of charge nurse and health centre manager posts is grade F, which is probably a reflection of the level of responsibilities that these posts carry.

Clinical nurse specialist posts and senior ward-based nurses are employed at Grade H. This grade was only reported by a small number of respondents (1.5 per cent in health centre three; 3.3 per cent in health centre one). Grade I, which was the most senior clinical grade available to nurses at the time of the study, was not evident at all. This reflects the poor development of specialist nursing posts in the service and the poor clinical career structure available to nursing staff.

Grade C is a grade exclusively given to enrolled nurses. Given the low number of enrolled nurse respondents in the study the low figures in this grade were not unexpected.

Table 11 cross-references job grade with job title, and clarifies some of the above data. For example, respondents in health centres two and three (20 per cent and 13.5 per cent respectively) described themselves as practitioner nurses, but did not relate this to a specific NHS Whitley Council grade. The cross-referencing shows that this mainly relates to staff nurses (86.4 per cent), with a small number of other

titles included such as: enrolled nurse (5.1 per cent); senior nurse (1.7 per cent); clinical nurse specialist (3.4 per cent); and health care officer (3.4 per cent).

	Job title (%)							
Grade	Staff nurse	Enrolled nurse	Senior nurse	Team leader	Charge nurse	Clinical nurse specialist	Health care officer	Health care manager
C	40.0	60.0						
D	85.3	11.8					2.9	
E	94.4	1.0	1.5	0.5	0.5	0.5	1.0	0.5
F	18.2	3.0	3.0		66.7			9.1
G			10.0	10.0	30.0			50.0
H			16.7		16.7	33.3	16.7	16.7
Practitioner nurse	86.4	5.1	1.7			3.4	3.4	
Clinical supervisor	28.6			14.3		57.1		
Health centre manager	5.9					5.9		88.2
Health care officer	4.0						96.0	
Senior health care officer							82.4	17.6
Principal health care officer								100.0

Table 11: Job title by grade

6.2.2.5 Age of respondents

Respondents were asked to give their actual age (see Table 12). The age profiles shows some differences that indicate that health centre three has a younger average age (36.1 years) than health centre two (38.8 years) and health centre one (39.5 years).

Centre	Mean	SD	Min	Max
Health centre 1	39.5	6.3	27	51
Health centre 2	38.8	9.9	27	58
Health centre 3	36.1	11.9	22	61

Table 12: Age of respondents

For reporting purposes the ages have been placed into five-year groupings (see Table 13). Examination of this table shows that higher percentages of respondents from health centre one were in the age grouping 36-40 (33.3 per cent), compared to health centre two respondents (16.9 per cent) and health centre three (17.4 per cent). Higher percentages of the 41-45 age band (26.7 per cent) were found in health centre one, compared to respondents from health centre two (20 per cent) and health centre three (17.6 per cent). Health centres two and three had higher numbers of younger nurses (age bands: under 25; 25-30; and 31-35) when compared to health centre one (see Table 13). This may be understandable when the data for grade and job title shows higher concentrations of senior nursing staff in health centre one.

	Health centre 1		Health centre 2		Health centre 3	
Age	**N**	**%**	**N**	**%**	**N**	**%**
Under 25			1	1.5	29	8.5
25-30	3	10.0	12	18.5	56	16.5
31-35	5	16.7	14	21.5	70	20.6
36-40	10	33.3	11	16.9	59	17.4
41-45	8	26.7	13	20.0	60	17.6
46-50	2	6.7	6	9.2	37	10.9
51-55	2	6.7	4	6.2	23	6.8
56 and over			4	6.2	6	1.8

Table 13: Staff age group

6.2.2.6 Professional qualifications of respondents

Analysis of respondents' professional qualifications by health centre is in Table 14. The main professional qualification identified in all three health centres was RGN, although the numbers were higher in health centres one (73.3 per cent) and two (69.2 per cent), than in health centre three (51.5 per cent). This was mainly accounted for by higher levels of RMN-qualified nurses in health centre three (23.2 per cent), in comparison to respondents from health centre two (16.9 per cent), and health centre one (16.7 per cent). There were higher numbers of dual qualified RGN/RMN staff in health centre three (8.8 per cent) when compared to respondents from health centres two (3.1 per cent) and one (3.3 per cent). This difference may have occurred because health centre three provides in-patient care services for a high number of prisoners with mental health problems. Also prisoners with mental health problems who need in-patient care would have been transferred to prisons with in-patient facilities.

RGN Registered Nurse
RGM Registered Mental Nurse
RMNH Registered Nurse for the Mentally Handicapped - now known as Registered Nurse-Learning Disabilities (RNLD)
RSCN Registered Sick Childrens Nurse

	Health centre 1		Health centre 2		Health centre 3	
Professional Qualification	**N**	**%**	**N**	**%**	**N**	**%**
RGN	22	73.3	45	69.2	175	51.5
RMN	5	16.7	11	16.9	79	23.2
RMNH			2	3.1	19	5.6
RGN & RMN	1	3.3	2	3.1	30	8.8
RMN & RMNH	1	3.3	1	1.5	4	1.2
Enrolled nurse general	1	3.3	3	4.6	24	7.1
Enrolled nurse mental illness					6	1.8
Enrolled nurse learning disability					1	0.3
RGN & RSCN			1	1.5	2	0.6

Table 14: Professional qualification

Respondents were also asked about the level of post-basic qualifications they held. There was a marked difference between health centre one where 46.7 per cent of respondents held no post-basic qualification, compared to 67.7 per cent of health centre two and 67.1 per cent of health centre three (see Table 15).

Higher qualifications were found in greater concentration among health centre one respondents where 16.7 per cent held degrees. This compares to only 5 per cent of health centre three respondents and no health centre two respondents. Many more respondents held diplomas. In health centre one the figure was 23.3 per cent of respondents compared to 16.9 per cent of health centre two respondents, and 15.3 per cent of health centre three respondents.

	Health centre 1		**Health centre 2**		**Health centre 3**	
Post-basic qualification	**N**	**%**	**N**	**%**	**N**	**%**
None	14	46.7	44	67.7	228	67.1
Certificate	4	13.3	9	13.8	30	8.8
Diploma	7	23.3	11	16.9	52	15.3
Degree	5	16.7			17	5.0
Masters					7	2.1
Not given			1	1.5	6	1.8

Table 15: Post-basic qualifications

6.2.2.7 Years qualified

Respondents were asked to state the number of years that they had been qualified as a registered nurse (see Table 16). Health centre two respondents had the longest average number of years since qualification (mean 14.1 years) compared to health centre one (mean 13.8 years), and health centre three (mean 13.6 years).

Years qualified	**Mean**	**SD**	**Min**	**Max**
Health centre 1	13.8	7.7	1.5	30
Health centre 2	14.1	9.3	1.0	38
Health centre 3	13.6	8.6	0.3	40

Table 16: Number of years respondents have been qualified

For reporting purposes years qualified were grouped as in Table 17. Analysis of data shows major differences between the health centres at the 16-20 year grouping, with 26.7 per cent of health centre one respondents reporting this time period since qualification. This compared to 10.8 per cent of health centre two respondents and 12.6 per cent of health centre three respondents. Nurses with exceptionally long service (that is over 30 years) were found in health centres two and three, and then only in small numbers.

	Health centre 1		Health centre 2		Health centre 3	
Years qualified	**N**	**%**	**N**	**%**	**N**	**%**
5 and under	4	13.3	9	13.8	56	16.5
6-10	7	23.3	20	30.8	106	31.2
11-15	6	20.0	12	18.5	57	16.8
16-20	8	26.7	7	10.8	43	12.6
21-25	3	10.0	6	9.2	41	12.1
26-30	2	6.7	5	7.7	27	7.9
31-35			2	3.1	6	1.8
36 and over			2	3.1	4	1.2
Not given			2	3.1		

Table 17: Grouped number of years since qualification

6.2.2.8 Years worked in secure environments

Respondents were asked to state how many years they had worked in secure environments (see Table 18). Health centre one respondents had worked for a mean 4.4 years compared to a mean of 5.8 years for health centres two three respondents.

Years secure environment	**Mean**	**SD**	**Min**	**Max**
Health centre 1	4.4	4.1	0.5	16
Health centre 2	5.8	6.2	0.1	41
Health centre 3	5.8	5.7	0.1	30

Table 18: Number of years the respondents have worked in secure environments

Years worked in secure environments have been grouped and are shown in Table 19. The largest grouping for all health centres is in the 1-5 years category, with 63.3 per cent of health centre one respondents, 47.7 per cent of health centre two respondents, and 52.4 per cent of health centre three respondents.

	Health centre 1		Health centre 2		Health centre 3	
Years secure environment	**N**	**%**	**N**	**%**	**N**	**%**
Under 1	2	6.7	10	15.4	35	10.3
1-5	19	63.3	31	47.7	178	52.4
6-10	4	13.3	15	23.1	69	20.3
11-15	3	10.0	7	10.8	32	9.4
16-20	1	3.3			17	5.0
21-25			1	1.5	6	1.8
26 and over			1	1.5	3	0.9
Not given	1	3.3				

Table 19: Grouped years in secure environments

6.2.2.9 Professional development

Respondents were asked a number of questions about aspects of their professional development, including:

- number of days training attended in the previous 12 months
- whether a professional journal was delivered to their work area
- whether they had access to a professional library at work
- how many items of professional literature that they had read in the previous 12 months.

Table 20 shows the number of training days by health centre. The table shows that health centre two had the greater number of training days (14.7 days) compared to health centre one (9.2 days), and health centre three (10.5 days).

Number of training days	Mean	SD	Min	Max
Health centre 1	9.2	6.6	0	30
Health centre 2	14.7	25.8	0	186
Health centre 3	10.5	15.8	0	150

Table 20: Number of training days in the last 12 months

A wide range of programmes are available to nurses in these areas, including academic programmes at a range of levels, together with skills-based programmes designed to meet organisational and individual need. However, many nurses have encountered access problems where either providers do not meet local needs, or they have problems with time off because of work pressures (UKCC and the University of Central Lancashire, 1999).

Many nurses also believe that the majority of training and development opportunities are focused around organised courses. They want a greater bigger emphasis on shadowing, secondments, conference attendance, project work and visits. A significant number of nurses mentioned that the study leave they undertook focused primarily on mandatory training rather than continuing professional development that related to their nursing role (UKCC and the University of Central Lancashire, 1999; HM Prison Service and NHS Executive, 1999).

Table 21 shows that greater numbers of respondents in health centre three (80 per cent) and health centre two (72.3 per cent) reported having a professional journal delivered to their workplace, than respondents in health centre one (56.7 per cent). Given the relative modest cost of these items and their potential for keeping staff informed of contemporary practice, funding for professional journals could be easily found.

	Health centre 1		Health centre 2		Health centre 3	
Delivered	**N**	**%**	**N**	**%**	**N**	**%**
Yes	17	56.7	47	72.3	272	80.0
No	13	43.3	18	27.7	68	20.0

Table 21: Journal delivered

Respondents from health centre three were also the most disadvantaged when it came to library access. Respondents in this centre said that only 26.7 per cent of them had access compared to 44.6 of health centre one respondents, and 42.1 per cent of health centre three respondents (see Table 22). This would add further weight to the argument to supply a regular journal to these areas.

	Health centre 1		Health centre 2		Health centre 3	
Access	**N**	**%**	**N**	**%**	**N**	**%**
Yes	8	26.7	29	44.6	143	42.1
No	22	73.3	34	52.3	192	56.5
Not stated			2	3.1	5	1.5

Table 22: Access to a library

Despite the disadvantages over library access and not having a journal delivered to their work area, this did not inhibit respondents from health centre three from reading professional literature. In the previous 12 months 73.3 per cent of health centre one respondents reported reading five or more professional articles or journals, compared to 64.7 per cent of health centre three respondents and 60 per cent of health centre two respondents (see Table 23). One of the reasons for this could relate to the higher numbers of staff holding post-basic qualifications in health centre one.

	Health centre 1		Health centre 2		Health centre 3	
Number	**N**	**%**	**N**	**%**	**N**	**%**
None	1	3.3	2	3.1	10	2.9
1-5	7	23.3	23	35.4	108	31.8
5 or more	22	73.3	39	60.0	220	64.7
Not given			1	1.5	3	0.6

Table 23: Number of items of professional literature read in last 12 months

It is suggested that nurses in prison settings need to have skills and knowledge that go beyond parts of the register. For example, RGNs need to have some knowledge of mental health and learning disabilities and vice versa (UKCC and the University of Central Lancashire, 1999; HM Prison Service and NHS Executive, 2000).

The future organisation of prison health care report (HM Prison Service and NHS Executive, 1999), and the recent *Nursing in prisons report* (HM Prison Service and NHS Executive, 2000) have identified that action needs to be taken to develop a strategy for the continuing professional development (CPD) of nurses working in prisons. The reports also suggest that the prison health care service is isolated from the mainstream of NHS development, and that the current training and development of health care professionals is patchy.

The UKCC *Nursing in secure environments report* (UKCC and the University of Central Lancashire, 1999) noted that there is a considerable resource for training and development and a wide range of validated courses already available. However, there appears to be no strategic approach to the development of nurses to meet patient and organisational need, and there is ad hoc CPD support.

The UKCC and the University of Central Lancashire (1999) criticised the low level of acceptance of clinical supervision. This may be because of practical problems such as management, isolation, and the lack of both formal or informal mentorship and preceptorship systems.

Although there appears to be a good understanding of what is necessary to properly induct nurses to work in prisons, these are often poorly implemented

6.2.2.10 Summary of demographic data

The analysis of the demographic data from staff questionnaire respondents indicates that the profile of respondents in health centre one settings is very different to the other two health centre settings. Respondents tend to be older and qualified for longer. Also health centre one respondents appeared more professionally disadvantaged to their colleagues in relation to access to professional literature and support.

6.3 Competencies

To rate each of the 45 competencies participants were asked a question about particular nursing practice that required two responses. For example, they were asked about whether their practice *contributes to the development of others.* First they had to respond with one of the following three answers:

- I am responsible for ensuring others undertake
- is part of my role
- is not part of my role.

Then second they had to make one of the following responses to the question in the light of *how important are these practices for nursing in secure environments?*:

- very unimportant
- unimportant
- undecided
- important
- very important.

The competencies have been grouped under 11 separate headings on the basis of shared thematic concepts. These groups are:

1. communication and relationships
2. assessment
3. care planning, implementation and evaluation
4. health and primary health care
5. discharge and community support
6. providing and developing therapeutic environments
7. safety
8. helping manage change and loss
9. staff support
10. professional development

11. management.

6.3.1 Importance

The rating of the competencies as either important or very important ranged from 87.2 per cent through to 98.3 per cent. This was consistent across all three health centres. Of the 45 competencies the vast majority were considered as either important or very important by over 90 per cent of respondents in all three health centres. It can be concluded that there was very strong support from the majority of nurses in all types of health centres for the importance of the competencies (see Annexe 1 for tabulated data for each of the competencies in relation to health centre).

6.3.2 Role

There were higher levels of supervisory activity reported from health centre one than in the other two centres. This related to both questions about *being part of their own role* as well as being *responsible for ensuring others undertake this* (the one and two combined category). These results probably reflect higher levels of senior staff respondents from health centre one. Also that health centre one tended to have fewer staff, which meant that senior staff carried out more hands on and supervisory duties.

The other general role difference was that health centre one respondents reported less involvement in psycho-social aspects of care. The type of service that they provide may explain this:

- a 9-5 GP service
- a more settled prison population with less psychiatric sickness (a prisoner requiring in-patient or more intensive psychiatric care would be likely to be relocated to a health centre three facility)
- staff are less likely to have psychiatric training and may feel less able to provide psychiatric care (see demographic data on professional qualifications).

6.3.2.1 Communication and relationships

Theme one brought together those competencies that are linked to *communication and relationships* (see Table 24).

Competencies one, two and three illustrate how health centre one respondents report higher supervisory activity levels.

Differences emerged for health centre one respondents in relation to competency 12 (enable individuals to develop meaningful relationships with others). Here 53.3 per cent stated that this was not part of their current role compared to 33.8 per cent of health centre two respondents, and 25 per cent of health centre three respondents. This is likely to be a feature of in-patient care as well as the level of involvement between the nursing staff and patients.

There were similar difference too in response to competency 24 (build and sustain relationships with individuals to reinforce their therapeutic goals). This may be due to similar reasons.

These results support the general assertion that there are higher levels of involvement in psycho-social care in health centres two and three. This is a particular feature of health centre three's in-patient services.

No.	Competency		Responsible for ensuring others undertake this (%)	This is part of my role (%)	This is not part of my role (%)	1 and 2 combined (%)	Not given (%)
Q1	Promote people's equality, diversity and rights	1	13.3	50.0	3.3	26.7	6.7
		2	10.8	75.4	3.1	10.8	
		3	11.8	68.8	4.1	14.4	0.9
Q2	Promote effective communication and relationships	1	10.0	60.0		23.3	6.7
		2	10.8	78.5		10.8	
		3	10.0	71.2	3.2	14.4	1.2
Q3	Promote communication with individuals where there are communication differences	1	10.0	56.7	3.3	26.7	3.3
		2	10.8	78.5		10.8	
		3	9.4	68.8	6.2	14.1	1.5
Q12	Enable individuals to develop meaningful relationships with others	1	6.7	33.3	53.3	6.7	
		2	3.1	50.8	33.8	7.7	4.6
		3	9.7	56.2	25.0	7.1	2.1
Q24	Build and sustain relationships with individuals to reinforce their therapeutic goals	1	10.0	53.3	23.3	10.0	3.3
		2	3.1	63.1	18.5	6.2	9.2
		3	7.9	75.0	8.2	7.4	1.5
Q26	Support individuals with difficult or potentially difficult relationships	1	3.3	70.0	16.7	3.3	6.7
		2	6.2	70.8	10.8	6.2	6.2
		3	7.1	70.6	10.3	8.8	3.2

Table 24: Theme 1 - Communication and relationships

6.3.2.2 Assessment

Theme two brought together the three competencies that deal with *assessment* (see Table 25).

Assessment was recognised as part of the role for all respondents regardless of health centre. Some differences emerged in relation to competency five (provide specialist assessment services on individuals' needs so that others can take action). Here 18.2 per cent of health centre three respondents did not see this as part of their work, compared to 6.7 per cent of health centre one respondents and 9.2 per cent of health centre two respondents. This may be because of in-patient care provision, the nursing of more severe illnesses and the availability of more specialised staff to undertake assessments.

No.	Competency		Responsible for ensuring others undertake this (%)	This is part of my role (%)	This is not part of my role (%)	1 and 2 combined (%)	Not given (%)
Q4	Assess individuals to determine their overall needs and risk	1	13.3	63.3	3.3	13.3	6.7
		2	9.2	78.5		12.3	
		3	12.4	74.7	2.6	10.0	0.3
Q5	Provide specialist assessment services on individuals' needs so that others can take action	1	13.3	53.3	6.7	16.7	10.0
		2	10.8	70.8	9.2	9.2	
		3	12.9	59.7	18.2	7.6	1.5
Q6	Assist in the assessment of, and the planning of programmes of care for, individuals	1	10.0	60.0	3.3	20.0	6.7
		2	9.2	75.4	1.5	12.3	1.5
		3	9.1	76.2	2.9	10.6	1.2

Table 25: Theme 2 - Assessment

6.3.2.3 Care planning, implementation and evaluation

Theme three grouped together five competencies under *care planning, implementation and evaluation* (see Table 26).

Analysis of responses to the competencies for this theme identified differences between all the three health centres, and in particular between health centre one and the other two.

In relation to competency seven (plan specific therapeutic interventions to enable individuals to recognise and address any socially unacceptable behaviour), 53.3 per cent of health centre one respondents did not see this as part of their role. This compares to 33.8 per cent of health centre two respondents and 18.5 per cent of health centre three respondents. The more intensive the service the more relevant this aspect of role became. A similar gradient of responses was seen in answer to competency nine questions (implement specific therapeutic interventions to enable individuals to manage their behaviour). In health centre one 43.3 per cent did not see this as part of their role, compared to 33.8 per cent at health centre two and 22.6 per cent at health centre three.

This trend was further reflected in competency ten (assist in the implementation and monitoring of specific therapeutic interventions). Here 36.7 per cent of health centre one respondents did not see this as part of their role compared to 18.5 per cent of health centre two respondents, and 15.9 per cent of health centre three respondents.

Perhaps unusually answers to competency 14 questions (contribute to the evaluation and improvement of programmes of care for individuals) showed that 20 per cent of health centre one respondents did not see this as part of their role for. While only 3.1 per cent of health centre two respondents and 4.7 per cent of health centre three respondents reported similar reactions.

These results show a lower level of involvement for nurses in health centre one services in therapeutic activity, compared to colleagues in health centre two services, and in particular when compared to respondents from health centre three services.

No.	Competency		Responsible for ensuring others undertake this (%)	This is part of my role (%)	This is not part of my role (%)	1 and 2 combined (%)	Not given (%)
Q7	Plan specific therapeutic interventions to enable individuals to recognise and address any socially unacceptable behaviour	1	3.3	26.7	53.3	6.7	10.0
		2	9.2	43.1	33.8	12.3	1.5
		3	10.9	60.0	18.5	9.4	1.2
Q8	Contribute to the joint implementation and monitoring of programmes of care for individuals	1	10.0	63.3	10.0	6.7	10.0
		2	4.6	75.4	4.6	13.8	1.5
		3	9.7	75.3	4.4	9.7	0.9
Q9	Implement specific therapeutic interventions to enable individuals to manage their behaviour	1	16.7	30.0	43.3	6.7	3.3
		2	9.2	46.2	33.8	7.7	3.1
		3	10.6	56.8	22.6	9.4	0.6
Q10	Assist in the implementation and monitoring of specific therapeutic interventions	1	16.7	26.7	36.7	13.3	6.7
		2	3.1	67.7	18.5	6.2	4.6
		3	8.5	67.4	15.9	7.9	0.3
Q14	Contribute to the evaluation and improvement of programmes of care for individuals	1	10.0	53.3	20.0	10.0	6.7
		2	4.6	78.5	3.1	7.7	6.2
		3	10.0	74.7	4.7	9.4	1.2

Table 26: Theme 3 – Care planning, implementation and evaluation

6.3.2.4 Health and primary health care

The competencies grouped under the theme of *health and primary care* can be found in Table 27.

For competency 15 (assess individuals' needs for primary health care services), fewer respondents in health centre three (11.8 per cent) identified this as part of their role. This compared to only 3.3 per cent in health centre one and 3.1 per cent in health centre two. For competency 16 (develop, monitor and review programmes of primary health care for individuals), 17.9 per cent of health centre three respondents did not see this as part of their role compared to only 6.7 per cent in health centre one and 7.7 per cent in health centre two. These results may reflect that the nurses work predominantly in in-patient services and have limited contact with primary care services. Although there is some form of internal rotation in all health centres, which usually means that staff have an opportunity to experience all aspects of the services offered.

No.	Competency		Responsible for ensuring others undertake this (%)	This is part of my role (%)	This is not part of my role (%)	1 and 2 combined (%)	Not given (%)
Q15	Assess individuals' needs for primary health care services	1	13.3	70.0	3.3	10.0	3.3
		2	7.7	75.4	3.1	12.3	1.5
		3	8.5	71.8	11.8	7.4	0.6
Q16	Develop, monitor and review programmes of primary health care for individuals	1	6.7	70.0	6.7	10.0	6.7
		2	6.2	73.8	7.7	10.8	1.5
		3	7.9	67.1	17.9	6.5	0.6
Q17	Contribute to raising awareness of health issues	1	10.0	60.0		23.3	6.7
		2	6.2	76.9	1.5	13.8	1.5
		3	9.1	77.1	3.8	9.1	0.9
Q18	Enable individuals to address issues which affect their health and wellbeing	1	13.3	66.7		13.3	6.7
		2	7.7	76.9		13.8	1.5
		3	10.6	79.7	2.4	7.1	0.3

Table 27: Theme 4 – Health and primary health care

6.3.2.5 Discharge and community support

Theme five concerned *discharge and community support*, and brought together a group of four competencies (see Table 28).

This theme gave the lowest figures for the identification of competencies in relation to the nurses' role across all three health centres. While there was greater identification with awareness raising of the needs of people discharged from prison, the promotion of their needs, involvement with placements and discharge packages were rarely stated as part of the nurses' role.

A number of factors relate to these results. Health care staff may feel relatively impotent in influencing issues around the movement and location of a discharged the prisoner. There may be a split between health care and the general prison community, and once a prisoner is discharged then health care involvement may be minimal. There may be uncertainty around whether nurses should be involved with prisoners after their

release. Also there are questions about whether there is any scope for nurses to liase with their NHS counterparts and communicate the health needs of the people who have been in their care. Clearly this is an issue that raises significant problems around confidentiality if a former prisoner does not wish this information or knowledge of his past to be divulged.

No.	Competency		Responsible for ensuring others undertake this (%)	This is part of my role (%)	This is not part of my role (%)	1 and 2 combined (%)	Not given (%)
Q19	Raise awareness of the needs of individuals discharged from your services	1	10.0	50.0	26.7	10.0	3.3
		2	4.6	61.5	20.0	9.2	4.6
		3	10.6	55.9	24.1	6.5	2.9
Q20	Promote the needs of individuals in the community	1	10.0	13.3	66.7	3.3	6.7
		2	7.7	29.2	50.8	7.7	4.6
		3	8.2	29.7	56.8	3.5	1.8
Q21	Negotiate, agree and support placements for individuals	1	3.3	26.7	63.3	3.3	3.3
		2	4.6	20.0	64.6	7.7	3.1
		3	6.5	33.2	54.1	3.8	2.4
Q22	Develop, monitor and review discharge packages to manage individuals	1	3.3	33.3	50.0	6.7	6.7
		2	7.7	24.6	56.9	7.7	3.1
		3	7.9	33.2	50.9	5.6	2.4

Table 28: Theme 5 - Discharge and community support

6.3.2.6 Providing and developing therapeutic environments

Theme six grouped five competencies together under the theme of *providing and developing therapeutic environments* (see Table 29).

The majority of respondents from all three health centres recognised that supporting patients when they are distressed is a part of their role. The major difference in this group of competencies, however, lay in the nurses' role in relation to competency 13 (enable individuals who are at risk to themselves and others to identify behavioural boundaries and develop control). In health centre one 30 per cent of respondents stated that this was not part of their role compared to 9.2 per cent of nurses from health centre two, and 9.7 per cent of health centre three respondents. This again appears to support the general assertion of the lower levels of involvement in psycho-social interventions in health centre three respondents.

More respondents from health centre three regarded competency 11 (enable individuals to develop and maintain skills of independent living) and competency 23 (contribute to the provision of effective physical, social and emotional environments for group care) as part of their role than respondents from health centres one and two. This probably reflects the in-patient population that they are providing care to.

However, relatively high numbers of nursing staff in all three health centre did not consider competency 31 (contribute to establishing and running mutual support networks) as a part of their role. Curiously the highest figure for this (51.2 per cent) came from health centre three. Given the figures for the other competencies in this group it is difficult to interpret why this should be the case.

No.	Competency		Responsible for ensuring others undertake this (%)	This is part of my role (%)	This is not part of my role (%)	1 and 2 combined (%)	Not given (%)
Q11	Enable individuals to develop and maintain skills of independent living	1	6.7	36.7	36.7	13.3	6.7
		2	3.1	55.4	27.7	9.2	4.6
		3	9.4	60.0	22.1	7.4	1.2
Q13	Enable individuals who are at risk to themselves and others to identify behavioural boundaries and develop control	1	10.0	43.3	30.0	10.0	6.7
		2	7.7	66.2	9.2	12.3	4.6
		3	11.5	68.8	9.7	8.8	1.2
Q23	Contribute to the provision of effective physical, social and emotional environments for group care	1	10.0	40.0	36.7	3.3	10.0
		2	3.1	46.2	40.0	6.2	4.6
		3	7.9	56.2	25.9	6.8	3.2
Q31	Contribute to establishing and running mutual support networks	1	3.3	43.3	43.3	3.3	6.7
		2	4.6	38.5	44.6	3.1	9.2
		3	5.3	37.6	51.2	4.1	1.8
Q32	Support individuals when they are distressed	1	10.0	66.7	3.3	13.3	6.7
		2	6.2	75.4	3.1	10.8	4.6
		3	6.8	80.6	2.4	9.1	1.2

Table 29: Theme 6 - Providing and developing therapeutic environments

6.3.2.7 Safety

Theme seven brought together five competencies under the heading of *safety* (see Table 30).

Results on these competencies reflect the working practices in all three health centres. Large numbers of respondents in all three health centres (between 44.6 per cent and 53.3 per cent) stated that competency 33 (create and maintain boundaries between the community and individuals detained in secure conditions) did not form part of their role. This may reflect the low level of nursing staff involvement in security procedures in some prisons, and the limited contact that nurses may have with the friends and family of prisoners.

A majority of nurses who responded from health centres three (75.3 per cent) and two (60 per cent) thought that competency 25 (physically intervene in situations where there is a breakdown in environments and relationships to limit risks to those involved) is a part of their role. While only 40 per cent of respondents in health centre one thought this. This may reflect the level of disturbance and psychiatric morbidity, as well as the way nursing staff providing in-patient care become directly involved in physical intervention with patients/prisoners. This may also explain why more nurses from health centre one (23.3 per cent) did not consider competency 34 (protect patients from themselves or others) or competency 35 (contribution to the protection of individuals from abuse) as part of their role.

Competency 36 (escort patients within and beyond secure settings) was more common for health centres three (60 per cent) and two respondents (38.4 per cent), than those in health centre one (20 per cent). This may reflect the greater need for escorting in-patients to internal and external appointments. The smaller staff numbers in health centre one would also make this exercise impracticable.

No.	Competency		Responsible for ensuring others undertake this (%)	This is part of my role (%)	This is not part of my role (%)	1 and 2 combined (%)	Not given (%)
Q25	Physically intervene in situations where there is a breakdown in environments and relationships to limit risks to those involved	1	3.3	33.3	53.3	3.3	6.7
		2	4.6	49.2	32.3	6.2	7.7
		3	6.8	60.3	22.9	8.2	1.8
Q33	Create and maintain boundaries between the community and individuals detained in secure conditions	1	3.3	26.7	53.3	10.0	6.7
		2	6.2	35.4	44.6	3.1	10.8
		3	5.6	40.3	45.6	6.2	2.4
Q34	Protect patients from themselves and each other	1	10.0	46.7	23.3	13.3	6.7
		2	9.2	61.5	16.9	7.7	4.6
		3	6.5	75.6	6.8	10.0	1.2
Q35	Contribute to the protection of individuals from abuse	1	6.7	46.7	23.3	16.7	6.7
		2	7.7	72.3	7.7	7.7	4.6
		3	6.5	76.8	5.9	10.0	0.9
Q36	Escort patients within and beyond secure settings	1	3.3	13.3	76.7	3.3	3.3
		2	7.7	27.7	55.4	3.1	6.2
		3	5.6	47.4	38.5	7.1	1.5

Table 30: Theme 7 - Safety

6.3.2.8 Helping manage change and loss

Theme eight comprised of four competencies under the title of *helping manage change and loss* (see Table 31).

A high number of respondents from all three health centres said that both competency 29 (enable individuals' partners, relatives and friends to adjust to and manage the individual's loss - 60.9 to 70 per cent) and competency 30 (enable individuals, their partners, relatives and friends to explore and manage change - 53.5 per cent to 66.7) was not part of their role. This perhaps reflects the low level of contact and involvement between nursing staff and the family and friends of prisoners/patients. This is particularly true from a therapeutic perspective.

More nurses in all three health centres considered competencies 27 (enable individuals to maintain contacts in isolating situations - 66.7 per cent to 75.6 per cent) and 28 (enable individuals to adjust to and manage their loss - 73.3 per cent to 85 per cent) as part of their role. Given the obvious distress and loss that prisoner-patients may experience this is likely to be an important aspect of the nursing role.

No.	Competency		Responsible for ensuring others undertake this (%)	This is part of my role (%)	This is not part of my role (%)	1 and 2 combined (%)	Not given (%)
Q27	Enable individuals to maintain contacts in isolating situations	1	6.7	53.3	30.0	6.7	3.3
		2	3.1	60.0	24.6	6.2	6.2
		3	6.5	62.1	22.6	7.1	1.8
Q28	Enable individuals to adjust to and manage their loss	1	10.0	56.7	16.7	10.0	6.7
		2	3.1	70.8	12.3	6.2	7.7
		3	6.5	71.5	12.1	7.1	2.9
Q29	Enable individual's partners, relatives and friends to adjust to and manage the individual's loss	1	3.3	16.7	70.0	3.3	6.7
		2	3.1	20.0	64.6	3.1	9.2
		3	5.0	28.5	60.9	3.5	2.1
Q30	Enable individuals, their partners, relatives and friends to explore and manage change	1		23.3	66.7	3.3	6.7
		2	3.1	21.5	66.2	1.5	7.7
		3	4.4	34.4	53.5	4.4	3.2

Table 31: Theme 8 - Helping manage change and loss

6.3.2.9 Staff support

Theme nine brought together three competencies under the heading of *staff support* (see Table 32).

Respondents who said that these competencies were not part of their role were likely to work in non-managerial or supervisory positions. It was surprising, however, that between 20 per cent and 23.1 per cent of the nurses in the survey did not accept that competency 40 (counsel and support staff in times of stress) was part of their role. This is not exclusively a function of supervisory practice, but it is a common experience and practice among staff in services such as nursing, and even more so in the demanding settings of prisons.

No.	Competency		Responsible for ensuring others undertake this (%)	This is part of my role (%)	This is not part of my role (%)	1 and 2 combined (%)	Not given (%)
Q38	Support and lead teams to enable work objectives to be met	1	10.0	43.3	30.0	6.7	10.0
		2	4.6	38.5	40.0	10.8	6.2
		3	8.8	45.9	36.8	6.5	2.1
Q39	Support staff in maintaining their identity and safe personal boundaries	1		53.3	33.3	10.0	3.3
		2	4.6	53.8	27.7	9.2	4.6
		3	7.4	60.3	22.6	7.1	2.6
Q40	Counsel and support staff in times of stress	1		70.0	20.0	6.7	3.3
		2	3.1	60.0	23.1	9.2	4.6
		3	7.1	62.9	22.9	6.2	0.9

Table 32: Theme 9 - Staff support

6.3.2.10 Professional development

Theme 10 grouped together three competencies under the heading of *professional development* (see Table 33).

No.	Competency		Responsible for ensuring others undertake this (%)	This is part of my role (%)	This is not part of my role (%)	1 and 2 combined (%)	Not given (%)
Q43	Contribute to the development of knowledge and practice	1	6.7	73.3		16.7	3.3
		2	4.6	75.4	3.1	13.8	3.1
		3	6.5	79.7	5.0	7.6	1.2
Q44	Develop oneself within the role	1	6.7	76.7	3.3	10.0	3.3
		2	4.6	76.9	3.1	12.3	3.1
		3	6.8	85.0	1.5	5.9	0.9
Q45	Contribute to the development of others	1	6.7	73.3	3.3	13.3	3.3
		2	6.2	73.8	3.1	13.8	3.1
		3	6.5	73.8	10.6	7.6	1.5

Table 33: Theme 10 - Professional development

Respondents from all three health centres placed a strong emphasis on professional development and very few nurses did not consider this a *part of their role*.

6.3.2.11 Management

Theme 11 grouped together three competencies under the heading of *management* (see Table 34).

No.	Competency		Responsible for ensuring others undertake this (%)	This is part of my role (%)	This is not part of my role (%)	1 and 2 combined (%)	Not given (%)
Q37	Manage one's caseload against the prioritised needs of individuals	1	6.7	60.0	16.7	13.3	3.3
		2	4.6	72.3	7.7	7.7	7.7
		3	8.2	61.8	20.9	6.5	2.6
Q41	Promote, monitor and maintain health, safety and security in the workplace	1	6.7	70.0	13.3	6.7	3.3
		2	3.1	76.9	4.6	12.3	3.1
		3	7.4	72.9	8.5	9.7	1.5
Q42	Receive, transmit and store information	1	10.0	73.3	6.7	6.7	3.3
		2	3.1	76.9	3.1	12.3	4.6
		3	7.9	77.1	5.3	8.8	0.9

Table 34: Theme 11 - Management

The majority of respondents in all three health centres recognised that management competencies are a part of their role. The variations that do exist may reflect individual nurses' position in the hierarchy and the level of autonomy that they exercise.

6.4 Audit results

As part of the UKCC Nursing in Secure Environments project (UKCC and the University of Central Lancashire, 1999) nine health centres were visited that provide all three levels of care, and an audit on nursing services was conducted (see Annexe 2 for audit results). To complete the audit observable evidence from the service was needed to show that the set criteria were being met (for example inspection of a policy document). The audits raised a number of issues, and for reporting purposes areas are identified where at least a third of the health centres failed to meet the standard.

6.4.2 Competencies needed by nurses working in secure settings

It was found that a number of nurses did not have access to their specific job description and a copy of current nursing job descriptions were not always available on the ward/department for reference.

Many of the health centres did not have at least one nurse trained in: clinical supervision techniques; teaching and assessing techniques; or preceptorship.

Many of the health centres had not undergone a skill/grade mix review in the last three years.

6.4.2 Are nursing interventions evidence-based?

In many cases a resource file of research papers relevant to the area of clinical practice was not available on the health centres.

6.4.3 The development of practice standards

Standards were not reviewed and audited systematically, nor were they always displayed for patients' information. Staff were not always satisfied with their level of involvement in the development of policies and procedures.

Prisoner-patients and their families did not always have access to a named nurse.

6.4.4 The preparation given to nurses

Of those services that had taken on new staff, some had not undergone an induction course organised by their new employers. Also new staff did not always have details of post and job description.

Many nurses did not have a named clinical supervisor and had not taken part in some form of clinical supervision during the last month.

Particular training deficiencies were found in relation to mental health legislation and guidance and de-escalation techniques.

6.4.5 Working with difficult patients

For those services that practised seclusion an identified seclusion procedure was not always evident and nurses were not always aware of the seclusion policy where it was available.

Following an incident there was not always a post-incident discussion with the patient.

6.4.6 Utilising UKCC policies to inform practice

Many nursing staff were not aware of UKCC guidance for: record keeping; mental health and learning disability nursing; or confidentiality.

A record of errors was not maintained by many services to demonstrate the investigation of the cause of error and the outcome, which would help to identify actions taken to avoid re-occurrence.

Where a new prescription replaced earlier prescriptions the latter had not always been cancelled clearly and the cancellation signed and dated by an authorised medical practitioner.

In relation to the administration of medication there was not always a clear procedure for identification of the patient, nor did the health centres always display a range of patient information leaflets concerning their prescribed medicines.

6.4.7 Practice issues relevant to physical health needs

Often there was no an identified health promotion nurse, nor were patients always offered monthly health check at ward level or an annual dental check up.

6.5 Case studies

Three health centres in England and Wales were visited to provide a cross section relating to:

- geographic location
- young and adult offenders, as well as women offenders
- the public and independent sectors.

The aim of the case studies was for the researcher to spend time with nurses in the services, observing the services at first hand and taking the opportunity to explore with them in the clinical setting the complexities and issues that they faced on a day-to-day basis.

Although the three health centres had many similarities, there were also critical differences in the way that their services were organised and delivered. Despite the publicised criticism of health care in prisons, all of the services offered a high standard of service. They were both open and welcoming to the researcher and allowed the probing of issues and free access to speak to staff and prisoners.

All of the services were given assurances about confidentiality. To ensure this observations are reported as an amalgam, and where the comment relates to only one service this is noted. Reporting these studies individually would have led to repetition and made confidentiality difficult.

Two of the three services employed nursing staff directly, with medical cover similarly provided by doctors and with contracts with a local general practice and a local NHS trust. The other service was provided through a contract with an independent sector provider, who in turn employed all of the health care staff directly on their own company terms and conditions.

In two of the three services there were no health care officers or other prison officers employed in the health care centres.

Each of the health centres had a clearly identifiable senior nurse in overall charge of the nursing services, who reported to a principal medical officer. Although there was some variation in the structures, the centres typically had around three senior nurses (usually at F Grade) who deputised for the nurse manager, while each had responsibility for different areas such as out-patients, in-patients and community work.

6.5.1 Principles of health care

The aim of the health centres is to provide as comprehensive a health care service as possible within the constraints set by the prison environment.

The services include medical, nursing, pharmaceutical and other health care specialists. They aim to deliver to a standard and quality set out in prison health care standards and equivalent to that provided by the NHS in the community.

Core aspects of the service are:

- a multi-disciplinary approach
- close liaison with colleagues throughout the prison and with health care organisations outside the prison
- a rigorous adherence to confidentiality
- the promotion of healthy lifestyles.

6.5.2 The reception and screening of new prisoners

For people who are sent to prison by the courts the reception unit is the first point of contact for them with both prison and health care staff,.

As part of the reception procedure, a nurse sees each new prisoner and a formal health screen is completed. This enables the nurse to form an initial assessment of the individual's needs. Unfortunately information at reception is often only available from the prisoner, unless other agencies involved have contacted the prison. Therefore, verification of initial health screen information may be required. Many nurses thought that the current national form in use for reception screening was at best a crude guide, and was not as helpful as it could have been in guiding the practitioner. Significant skills were still required to administer the form and identify the health problems of the new prisoner. More could be done to help to support the nurse in this process.

The result of this initial assessment, together with the doctor's assessment that takes place within 24 hours, determines whether the prisoner will need in-patient treatment in the health care ward or be followed up in outpatients.

If the prisoner needs to be admitted to the health care centre the reception nurse liases with the ward staff. If the prisoner goes onto a prison wing the nurse liases with unit staff to make them aware of any relevant issues about the prisoner's health.

During the reception process the new prisoner will also be informed of how to access health care if they require it in the future.

The nurse is also available at reception to give advice, support and assessment to any prisoner who has returned from court, been transferred to the prison from another prison or returned from bail.

Numbers vary to anything between four and 40 arrivals a day, and they invariably occur in the late afternoon or early evening as the courts close. Many newly admitted prisoners claim to be drug addicts and request detoxification urine screening. This is performed to offer some objective confirmation.

6.5.3 Health needs

The main health needs described by the health centres focus on:

- sports or fighting injuries
- respiratory conditions (particularly asthma) related to the high incidence of smoking
- mental health problems particularly depression, anxiety and stress-related conditions
- self-injury and self-neglect
- rashes and spots
- epilepsy
- diabetes.

The protocol in one of the services for lacerations was that nurses needed to perform 14 suturings a year to maintain competency. This was rarely possible. Further the protocol stated that nurses should not suture faces.

6.5.4 Treatments and therapy programme

Allocated keyworkers at the services visited who devised individual care plans for their patients. Group work and individual counselling was also available depending on the needs of the unit population.

Keyworkers also co-ordinated and liased with other agencies who may be providing after care for the patient to ensure a smooth transition takes place. A discharge summary is completed on discharge from the in-patient unit, giving clear and accurate details of any future management issues regarding the prisoner's individual needs.

The keyworker aims to ensure that continuity of client care is maintained and care plans are kept accurately and appropriately. General standards for keyworker systems include that they:

- are a first level nurse or health care officer
- are allocated within 24-hours of admission to the unit
- carry out all appropriate assessments
- are responsible for the management of all aspects of care for their allocated client, including psychological, physical, emotional and spiritual
- are responsible for developing a comprehensive plan of care for their client
- are responsible for liasing with other agencies involved in their client's care while in prison and prior to release
- ensure effective communication is developed with all other team members regarding their client's care
- attempt to spend one-to-one time with their client during each shift
- ensure the ward doctor receives up-to-date and accurate information regarding their client at the multi-disciplinary team meeting
- refer their client to a liaison nurse on discharge from the unit if required
- ensure discharge summary is completed prior to discharge back to their unit.

Nurses also had the responsibility of ensuring that all discharge and follow up letters to GPs were organised for prisoners coming up to release. This was not a feature of the keyworker role, but attached to other duties

such as outpatients. In many respects this is an administrative task that did not necessarily require the involvement of a health professional.

6.5.5 In-patient care

The units provide acute physical and mental health care on an in-patient basis for the prison population and aim to ensure that all patients are individually assessed, treated objectively, humanely and with dignity. In all cases where in-patient beds were available occupancy levels were 50 per cent. Not all facilities were purpose-built but had been adapted from cell blocks. Observation tended to be a problem on this unit and it lacked the flexibility of facilities enjoyed by the purpose-built units. One interesting observation was that this unit lacked 'in-cell power' which was available to prisoners throughout the rest of the prison. Consequently this acts as a deterrent for admission as prisoners are unable to use their electrical equipment while in-patients.

Some of the health centres have facilities for routine x-rays, but normally they are carried out at the local hospital.

6.5.6 Ward team

The ward teams consisted of team leaders at senior officer or F grade level, and a team of first level nurses who were registered mental nurses, registered general nurses or health care officers.

Medical care was provided on a daily basis from unit doctors and there were a number of visiting psychiatrists who see in-patients on a weekly basis.

A principal medical officer, clinical nurse manager and health care principal officer provided senior management.

6.5.7 Admissions to units

There are a number of ways that a prisoner may be admitted to the units, these are:

- owing to acute physical or mental illness
- following a serious episode of self-harm
- from an outpatient clinic with a visiting psychiatrist, GP or the prison medical officer
- from reception, following either a nurse or medical officer assessment
- owing to the nature of charge - prisoners may be admitted if they have committed a particularly serious crime for assessment
- following discussions with discipline staff, governors, psychology, probation, social worker and other members of the multi-disciplinary team who may have concerns regarding a prisoner's welfare.

On average the diagnostic split of in-patients was approximately sixty per cent mental health problems and forty per cent physical health problems. Included in the mental health group were prisoners described as poor-copers (meaning that these were prisoners who struggled to adapt to the prison regime), prisoners who self harmed, those prisoners seeking sanctuary from bullying, and the problem of illicit drug abuse.

6.5.8 The outpatients departments

The outpatient departments (OPD) provide health care for the prison population who remain in residential units. The departments tended to open daily and are staffed by a mixture of nurses and health care workers.

Prisoners wishing to see a doctor, dentist, genito urinary medicine (GUM) specialist or optician do so through a self-referral system. The department also organises the forensic reports completed by visiting psychiatrists for court proceedings or health referral. If the prisoner is involved in an incident such as a fight then the rules state that they must be seen by a doctor within 24 hours. If acutely unwell they can report sick at any time. Prisoners are initially seen by a nurse and referred to a doctor if necessary, or treated there and then. The outpatients departments also tended to provide emergency cover for first aid to the prison units.

The outpatients departments have responsibility for issuing medication to the residential units.

The following services are available in OPDs:

- primary care (general practitioner) clinics
- medical officer clinics
- genito urinary medicine (GUM) clinic
- dentist (usually by contract to local NHS providers, each of the services visited reported a backlog in routine work and only just keeping ahead of emergency treatments, often prisoners had poor dental care on reception)
- nursing - outpatients (providing emergency, primary and secondary health care from first aid, dressings, medical treatments, advice, counselling, health promotion, health screening)
- escorts and bedwatches (occasionally the health care centre is not able to provide the specialist medical or surgical treatment a prisoner may require, therefore, escort to outside hospital is required).

6.5.9 Prison community care

The services visited had different types of prison community care[1] in development and operation providing nursing input and advice to the whole of the prison. One service assigned key nurses to prisoners with psychiatric problems who would be in residential units. Their responsibility was to keep track and provide support and guidance during their stay.

The services aimed to enable the prisoners on the units to achieve their optimum level of functioning through:

- establishing therapeutic relationships with the prisoner, and good working relationships with unit officers to ensure continuity of care
- giving advice and support, planning and follow-up care
- attending case conferences and contributing to the discharge planning process
- developing 1:1 counselling and group work
- providing support to unit staff when trying to deal with difficult/problem prisoners
- liasing with agencies both within the prison and outside that may contribute to the care and follow up of the client.

Nurses also offered a form of triage for prisoners in the residential units, sometimes combined with drug administration. Some prisoners felt that they were not given sufficient time during these encounters with the

[1] Increasingly health care is being seen as involving not just the services available in the health centres but also the health needs of the prisoner throughout their sentence embracing the prison as a whole. This is variously termed, wing-based care, in-reach, and out-reach. For the purposes of this study the preferred term used was 'prison community nursing', which has a less institutional feel and cannot be confused with terms used for other purposes (for example the term in-reach is often used to describe NHS services being extended into prisons).

nursing staff and that they would have valued a longer consultation. In many respects this may be about pressure of time for the nurse who is attempting to combine this service with other pressing demands such as drug administration.

One of the services had strong anti-bullying policies and procedures in place throughout the prison and it was felt that this was a significant factor in reducing the number of admissions to the in-patient facilities from those people seeking sanctuary.

6.5.10 Health care administration departments

The administration departments are responsible for supporting the whole of the health centre in relation to the outpatient clinic, waiting lists, and call-ups with the help of the new health care data base system (HISP).

This system also enables records to be kept of all movements in the centres, including in-patients, clinics, outside hospital appointments and medical reports.

Every prisoner on reception to the prison has a medical record (IMR) so there is a vast store of records for both current and discharged inmates. The main function of the administration staff is the maintenance of systems to ensure all transfers, discharges and clinics are accurately recorded on a daily basis.

6.5.11 Pharmacy department

One of the health centres visited in a young offenders unit had a large in-house pharmacy. It not only served the unit but several other prisons in the locality, and dispensed over 5,000 prescriptions each month. The other centres visited used the services of other prison pharmacy departments. There seemed to be distinct advantages in having a pharmacy on site, not least of which was their ready availability of support and advice, and the running of lunchtime education sessions for staff. Not all of the services had a prescribing formulary or an active drugs and therapeutics committee that would have been clearly advantageous to the nursing staff.

The pharmacist at the young offenders institution was able to provide details of all the medication issued in the previous 12 months (Table 35). This profile of drug prescribing provides some insight to the range of conditions being treated by the health centre and the health needs of the population. The profile is clearly distinct to the age of the population (for example the high percentage of prescriptions to deal with acne) and it would be expected that an adult prison would have a different profile to this. However, some of the common conditions span all age groups including prescribing for analgesics and anti-psychotic medication.

Medication Type	Percentage
Analgesics	19
Anti-psychotics	18
Drug abuse - Opiate	12
Antidepressants	9
Antibiotics	9
Sedatives	7
Acne – oral	6
Asthma - reliever	6
Asthma - steroid	4
Acne - topical	4
Hay fever	3
Anxiolitics	1
Nicotine patches	1
Drug abuse - Alcohol	1
Total	**100**

Table 35: Medication use in young offenders institution (Jan-Dec 2000)

It was unsurprising to see anti-depressant and hypnotic medication featuring strongly as the young men struggle to come to terms with life behind bars.

The main physical conditions that needed treatment were respiratory conditions. Steroid and non-steroid inhalers were used for asthma control and relief and a high number of hay fever preparations were also prescribed.

6.5.12 Issuing of medication

Medication is prescribed either as *in possession* or *not in possession*. According to local guidelines agreed with medical staff and the pharmacist all psychotropic drugs, drugs liable to abuse or drugs for clients in danger of self-harm (overdose), are not allowed *in possession*. Also medication in glass containers is not issued *in possession*.

Prescriptions for *not in possession* medication are dispensed in plastic patient- named bottles for the duration of the prescription for daytime treatment, and in Venalink blister packs for all night-time medication.

Prescriptions for *in possession* medications are all dispensed in seven-day Venalink blister packs, except for liquids, which are dispensed in weekly amounts in plastic bottles; creams and ointments or ear/eye/nose drops etc, are dispensed in their original containers.

6.5.13 Nurse prescribing

Prescribing by nurses is currently limited to formulary including:

- Paracetomol
- Aspirin
- Ibuprofen
- cough/bronchial pastilles,
- simple creams
- Bonjella
- haemorrhoid creams
- Mycil powder
- Magnesium Sulphate.

Nurses were also able to give stat doses of detoxification drugs at admission where indicated.

Nurses were concerned that the extending of the prescribing formulary for nurses had some potential pitfalls. The main problem identified was that nurses, who were in close proximity to prisoners for significant periods of time, could be subjected to significant pressures to prescribe medications. This would be particularly so for substances of abuse such as strong analgesics or drugs such as Valium.

However, it was felt that an extended formulary for nurse prescribing would be valuable for dealing with problems such as tooth abscesses, pain relief, septic throats and ear problems. The ability, therefore, to prescribe drugs such as antibiotics and Brupheren, and be able to modify prescriptions and dressings, was felt would save time and lead to quicker and more responsive care for the prisoner. In many respects nurses stated that the necessity for nurse prescribing often depended on the medical cover available.

6.5.14 Liaison with other agencies

Good communication and exchange of information with other sections of the prison and other agencies both inside and out is encouraged. This included close working relationships with the essential professional groups and organisations in the prison community such as unit staff, personal officers, probation, psychology, education, chaplaincy and the Board of Visitors.

Links have been established externally that enable the health care centre to remain fully informed of current practice especially in the field of forensic mental health.

In one service nursing staff complained that there were significant problems in dealing with the after-care of prisoners post-discharge owing to the differences in the care programme approach, particularly between England and Wales.

6.5.15 Staff development (in-service training)

New staff to the health care centres are given an induction training programme that includes instruction on topics that are relevant to the activities both within the health care centre and the prison.

One service offered regular training seminars to all staff held in the health care centre. These seminars covered a wide range of relevant topics to the unit.

Nurses interviewed complained that the funding for post-registration was complicated and labyrinthine, and consequently acted as a deterrent for nurses. One service had an agreement with local colleges that offered

their courses free-of-charge to the nursing staff and some had taken advantage of generic courses on topics such as sports injuries.

One health centre was compiling a small reference library of basic text books, reprints of key articles and relevant material open to all staff.

Another health centre was a pilot site for clinical supervision, and had benefited from the input of local nurse academic staff who were helping to establish a system of supervision. In the other health centres, however, clinical supervision was not taking place despite this being a requirement of the prison services health care standards.

6 Focus groups

6.6.1 Northern Ireland focus group

The focus group for Northern Ireland was established and took place early on in the study. A cross-section of nursing staff and health care officers from the two Northern Ireland prisons took part in a two-hour focus group in HMP Mughaberry (eight participants from HMP Mughaberry, HMP Magilligan and HM Young Offenders Centre).

Attendees felt that the most obvious and striking difference that impacted on the role of the nurse were security issues. Security, they felt, slowed down the health care process, and is tedious. They said that the nurse is faced with a wide range of issues that need to be considered other than health care.

Security places restrictions on the freedom of the nurse to carry out their job. For example, during lock up time it is very difficult to get things done because of restricted access when it is sometimes not possible to even speak to a prisoner. Nurse on the focus group said they appreciated the necessity of the security procedures, but acknowledged that when the primary purpose of the organisation was not health care but security, this created a tension.

They also felt that to work successfully in these very restrictive and tough environments it is necessary to develop good relationships with prison officers. Recent changes, which have given the nurses prison officer status, has made a positive contribution to this and helped nurses with issues of access and assessment. The nurses reported an increased authority and acceptance with other prison staff and were now regarded as part of the team in responding to an incident, whereas before they had to withdraw.

It was felt that nurses were still treated with a great deal of respect for their professional status by prison officers. The changes have meant that they can now carry keys, escort prisoners, and inspect prisoners' logs, which they had previously been denied and had to rely on prison officers for. Consequently, they felt the revised role has given nurses more freedom to carry out their job.

The new arrangements have helped to resolve issues in relation to pay. Nurses are now paid to reflect rank, and the arrangements are more cost-effective than the previous regime.

Some nurses on the focus group felt that the new arrangements may prove to be a slight disadvantage in the long-term because they now have the authority of prison officers and the power to put a prisoner on a charge for such things as abusive language. This can mean a prisoner facing an adjudication hearing, which can be intimidatory and frightening. The result of such hearings can mean the loss of privileges or additional days added to the prisoners' sentence. Some nurses felt that this situation could threaten the patient/nurse relationship, while others thought that as long as such powers are used sparingly, they have to be accepted as part of the environment of the organisation. It was acknowledged that some prisoners were very violent and

that health professionals should have some protection and redress from extremes of abusive language and behaviour. In reality only one of the group had used the power to charge on a single occasion, and on this occasion felt that it helped the dynamics of the relationship with this particular prisoner.

In relation to the nurses' role, attendees spoke of the breadth of the job that they were faced with. In particular prisoners needs were often multi-faceted with not just mental health problems but also complications such as severe self-injury. Consequently the focus group thought that nurses in the service need a broad knowledge encompassing all aspects and branches of nursing. The primary care role and mental health role were not seen as separate, although there is some follow-up by community psychiatric nurses not from a local NHS trust for assessments. The experience of colleagues is valuable to draw on and so they said that attention to skill mix was important, and the knowledge needed is more about breadth than depth. Attendees argued that some skills all nursing staff will require, such as resuscitation, yet there are areas where individuals can and do specialise such as in asthma, diabetes or drug abuse care. In reality all nurses have a basic generic role but with a secondary specialist role attached.

The focus group said that the recent staff changes and recruitment had given good staffing levels and there was a need to provide focused training for the new recruits as well as those staff already in post.

Some nurses were concerned about becoming de-skilled the longer that they remained outside the NHS, and that this could be a barrier to them if they wished to return. However, attendees also recognised that they would also develop new, more generic skills.

They said that the general structure of the services could be described under the subheadings of:

- in-patient care
- outpatients
- reception and screening
- prison community care.

However, all staff rotated through these roles and a working knowledge of all four elements was necessary. Some staff felt aggrieved at times, particularly those in mental health care when they were removed to carry out other duties. This, however, has improved considerably since the staffing increases.

It was felt that if there were to be a nurse consultant post it should reflect the broad basis of the role with some specialisation rather than being purely specialist.

It was also felt that prisoners often needed the help of other non-health professionals and examples of the Samaritans and chaplaincy were given.

The focus group thought that extending the nursing formulary for nurse prescribing would give nursing staff, and to some extent medical staff, more freedom and lead to care being provided more quickly. Currently some prisoner/patients need to wait until the next day for treatment when a member of the medical staff is available, or a GP has to be contacted by telephone. Some over-the-counter medicines can be given when necessary, but the ability to sign repeat prescriptions was said to be particularly helpful.

The nurses felt that it was likely that prisoners would pressurise nursing staff for prescriptions, and consequently prescribing should be limited to drugs not known to be subject to abuse. Prescribing rights should not be available to all nurses but limited to those who had undergone a specific preparation for the

role and limited to specific situations, and working to a limited formulary. It was noted that in certain circumstances nurse were currently more knowledgeable than junior medical staff in prescribing. Further exploration of the issue would be helpful as there was uncertainty whether this was enough of a problem to necessitate the change.

6.6.2 Scottish focus group

A representative group of nursing staff from eight prisons across Scotland took part in a focus group in HMP Edinburgh.

The Scottish prison nurses described how their system differs from that in England and Wales because it uses registered nurses only, rather than employing health care officers. The staff and managers thought that this provided opportunities to develop nursing practice, and they felt that the Scottish service held significant advantages over the England and Wales system. They also thought that five to 10 years ago they had been totally isolated from other prison services and that today there was much closer liaison and working.

The nurses stressed some of the personal qualities required of them in the operational constraints of the prison regime, including resilience in handling pressure, and a degree of maturity and life experience. It was felt that the environmental issues were such that some people couldn't cope.

The need for a balance to be struck between security and therapy was stressed together with a need for specific training in security procedures. The focus group stated that health care standards varied depending on the type of prison.

They described their role as generic because it covered all aspects of care. A nursing qualification was required with an add-on from other branches. This was seen as the way that individuals developed the right skills mix. Being both a registered mental health nurse (RMN) and registered nurse (RGN) was seen as a distinct advantage. The group thought that all nurses were required to attain a broad base competency because the service was not big enough to be able to afford to pay for nurse specialists.

They described themselves as coming from a broad spectrum of backgrounds, and commented that if nurses had taken further training than this was beneficial. The focus group attendees felt that RMN's have a better mechanism for coping in the prison environment and very experienced RMN's have coped best. It was suggested that psychological skills are very difficult to pick up as opposed to purely technical skills.

In their experience the key problems experienced had included nursing drug addiction (90 per cent of women with these problems), confidentiality issues, and the problems of remand prisoners issues (people with huge health needs that cannot be addressed in the seven to 10 day remand period).

The nurses stressed the rigour of 24-hour duty of care and that they were often a 'jack of all trades'. It was felt that prisoners often target nurses as an avenue to get what they want, which is often nothing to do with health care. Prisoners see nurses as potential advocates and not as embroiled in the system as prison officers. The nurses thought this may be because nursing had been disengaged from discipline for the last of five years.

Nurses felt that expectations of the prisoners are now much higher and they get access to care much more quickly than they might do if they were living in the community.

It is the norm for nurses to give prisoners health screening before they see the doctor. This means that two-thirds of prisoners are seen by nurses and never go on to see the doctor. Attendees felt that it was important that the nurse was able to see beyond the prisoner to a patient.

Focus group attendees described the difficulties of working in the prison setting. The nurses said that they:

- received very little positive feedback from the patients in their care
- never had enough resources and were forced to prioritise
- were faced with health care standards that were idealistic
- were faced with a management more interested in performance indicators and not about the quality that lies behind it.

On education issues the focus group said that one of the key problems was releasing staff to attend training courses. This was particularly acute in smaller prisons where staff can often be working on their own. They described how courses were organised when there was enough critical mass of numbers.

The nurses thought it was important to aid induction of new staff by asking people to work one of two shifts through an agency before applying for a post. It was acknowledged that nurses had sometimes started the job before they attended an induction course. It was stressed that what happens after induction is equally important and that it is up to people with the experience to share their expertise with their new colleagues. Often this induction in the clinical environment could benefit from more structure.

Focus group attendees described a high proportion of difficult patients among the prisoners they cared for, and felt that wider availability of clinical supervision would be beneficial. A range of problems were described including:

- prisoners covering up following incidents
- manipulation
- litigation
- exploiting weaknesses.

Medication was highlighted as problematic. They described difficulties in:

- drug administration
- inexperienced prescribers
- on discharge GPs undermine work when prisoners are put back on previous drug regime
- an ever present illicit drug problem.

Focus group attendees described the UKCC guidance as being a mixed blessing because it provided standards to work towards without insight into the prison environment. An example of this was cited as the guide to the administration of medications which 'mentions every environment but prisons'. In the end the attendees felt that the answer lay in professional accountability.

A wide range of health initiatives were described that included weekly GUM clinics and midwifery input, and primary care was described as generally good. It was stressed that prisoners are not always in the best of health when admitted to prison and many have been previously struck off by their GPs. Consequently attendees felt that many prisoners got better health care than when they were living in the community.

On a general note the nurses said they recognised the need to include other professions, also discipline officers in getting their views about health care together with the views of governors. It was recognised that everyone who works in the environment will have an impact on health care and there is a strong co-dependency with medical and nursing staff.

7. Discussion

When looking at the role of nurses working in prison health care settings two aspects appear to predominate:

1. the problems of providing care in a secure environment whose primary purpose is not health care
2. the role is more about breadth than depth.

The nurses were asked what was the single factor that made their work different, and what was the initial impact of coming to work in the prison service. They unanimously told the researchers that the problems of adapting to the security procedures predominated over all other considerations, including at times health care. They said that they found the physical security of the environment often awesome and at times intimidating. They often spoke of the unique culture of the environment that was not well suited to the values and aspirations of professional nursing practice.

What makes prison nursing different or special is the setting in which it takes place and the expectations placed on the nurse role to meet the health needs of the prisoner population, which demands a tremendous breadth of knowledge often encompassing all four parts of the professional nursing register. Clearly there are the physical health needs of the prisoners which, despite being a predominantly young and active population, present with the full spectrum of physical ailments. Mental health problems are much higher for this group than in the general population and at much higher levels of density than a nurse would encounter in mainstream practice. Combined with this, large numbers of people with a learning disability are found in the prisoner population than in the general population. Also in young offenders institutions nurses are faced with meeting the complex needs of adolescents and young people.

This suggests a breadth of problems perhaps unparalleled in any other form of nursing practice. It would be difficult to say which branch of the profession would best prepare nurses for their work in this setting, in many respects it might depend on the type of health centre.

Health centres one and two lean towards the adult branch, while health centre three uses either the adult and/or the mental health nurse training, depending on the type of work. However, whichever original training the nurse has undertaken there will be a steep learning curve in relation to increasing the breadth of their knowledge and the contextual issues of institutional care.

It was possible to identify sub-roles within the general roles that nurses were performing. Some nurses predominantly stuck to one of these roles, such as the in-patient nurse. Other roles were limited by the type of health centre they worked in (such as health centre one), but the norm was that nurses in the larger health centres would be rotated through these sub-roles and expected to be proficient in all aspects of care.

Figure 1 presents an overview of the key elements that were identified in this study as forming part of the role of the nurse within the prison service. Clearly within each of these sub-roles are a range of competencies. They complement the 45 competency statements tested in the UKCC secure environments project staff questionnaire. These competencies could be expanded to help clarify the specific demands of the practice setting.

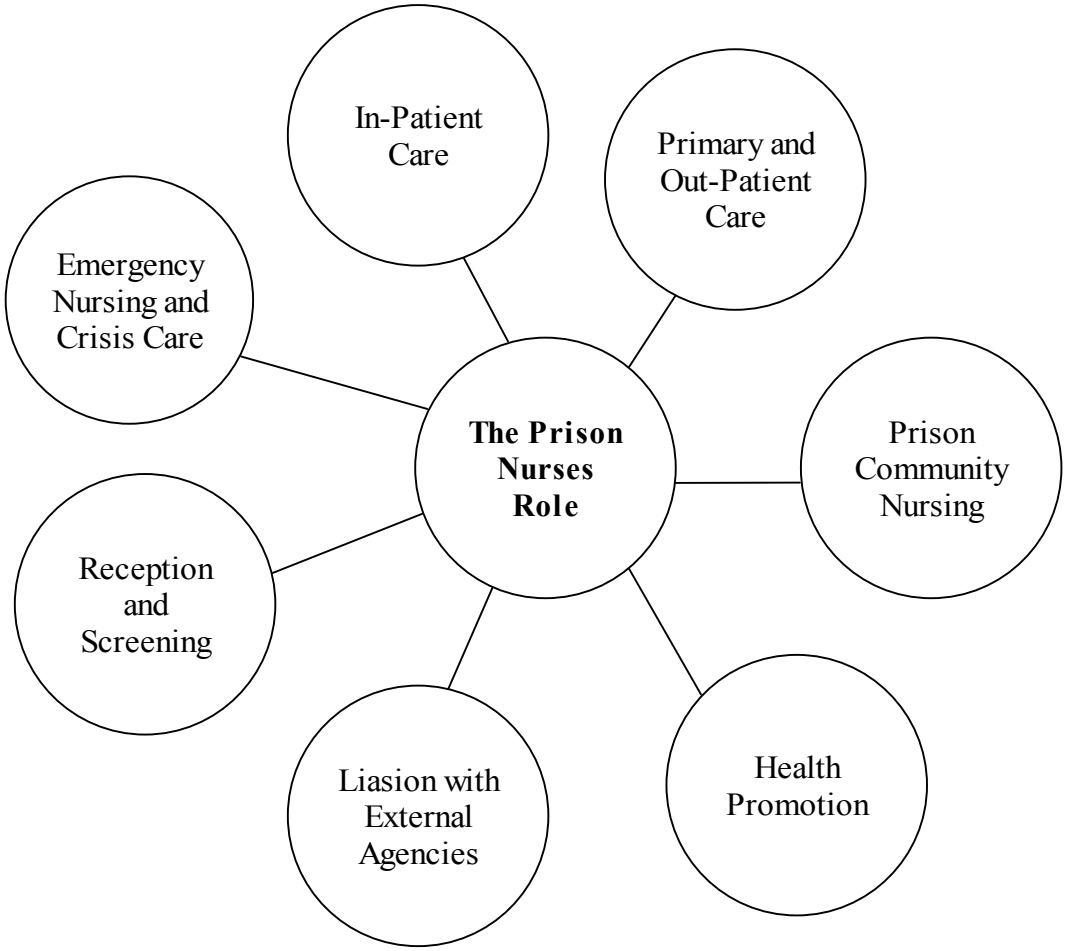

Figure 1: An illustrative model of the aspects of prison nursing

7.1 In-patient care

Health centres three and four are designed to provide intensive in-patient care for prisoners physical and mental health problems. Of the units visited the proportion of prisoners with mental health problems were approximately sixty per cent. Occupancy levels were relatively low at fifty per cent, but it was felt that this depended on the attitude of the governor grades to the use of health care beds. In some services high occupancy rates can be attributed to the placing of vulnerable prisoners in the health units who do not present with health needs. Many nurses felt that this use of the beds was inappropriate.

The role of the nurse in these units reflects any in-patient setting with its routines of care and ward management. The difference for the prison nurse is the broad diversity of the patient's needs ranging from post-operative surgical care, medical illnesses and a range of psychiatric symptoms. This mix creates specific challenges for the skill range of the individual nurse as well as the mix of skills held by the group as a whole, which need to be responsive enough to meet varying demand. The added challenges for the nurse are maintaining the security requirements of the unit and for times during the day prisoner-patients will be locked into adapted cells in most health centres.

7.2 Primary and outpatient care

Primary and outpatient care is a consistent feature of health centres in all prisons. While there are variations in the size and scope of facilities they all offer opportunities for prisoners to consult with medical staff on health concerns. The larger facilities offer an array of specialist clinics including:

- GUM
- asthma
- dentists
- opticians.

Increasingly more specialist services are now provided in primary care including specialist nurse-run clinics, mental health services, drugs and alcohol services and diabetes care. These services are linked to secondary hospital-based services, and there are examples where individual nurses take a specialist interest in a given topic and have received specialist training to build up their expertise. There are a number of health conditions in the prison population that occur frequently enough to justify setting up specialist services and appropriate training with links to the local NHS.

Nurses are required to have significant organisational skills in running an outpatient department, and in the smaller health centres this study found that nurses in senior positions had to turn their hands to all aspects of the work of the department.

The high costs and risks involved in escorting prisoners to NHS hospital-based outpatient appointments has meant that health centres have begun to examine what it would be possible to offer in the prison health centre. This potentially offers nurses increased opportunities for role enhancement and development as well as increasing interest and job satisfaction. Belmarsh prison is scheduled to pilot tele-medicine, which might also reduce outpatient attendance at NHS hospitals and offer cutting edge experience for nurses.

7.3 Prison community nursing

Increasingly health care is seen as embracing the prison as a whole and involving not just the services available in the health centres, but also the health needs of the prisoner throughout their sentence. This is variously called, wing-based care, in-reach, and out-reach. For the purposes of this study the preferred term used was prison community nursing, which has a less institutional feel and could not be confused with other expressions such as in-reach which is often used to describe NHS services used in prisons.

Recently (HM Prison Service and NHS Executive, 2000) there have been calls for a systematic study to identify the best use of wing-based care (sic), which has greater possibilities for involving all prison staff in health promotion and observation. From the focus groups and case studies conducted in this study it was clear that a variety of models existed. Some nursing staff were permanently attached to specific units that ran treatment programmes such as drug rehabilitation. Other nursing staff regularly visited the prison units and provided some treatment sessions there using group work or individual therapy sessions as well as providing support to prison staff in devising the most appropriate response to problems. Nursing staff visiting the prison units for other purposes such as drug administration were often called upon by prisoners and/or prison officers to provide advice and triage particular health queries.

It may be more appropriate in some prisons to deliver more care on the wings or in day hospital facilities. Some additional work could explore this for future reference. In particular it would be useful to examine how the nurse may be better supported in undertaking this aspect of role.

7.4 Health promotion

There are examples of a range of health promotion activities in prisons targeted at the specific needs of the prison population, which include mental health, drugs and alcohol, HIV and hepatitis, immunisations, testicular cancer, and smoking.

Some health centres are also using life-style questionnaires and routine health checks for blood pressure and cholesterol for both prisoners and the staff.

As prison governors develop a settings or healthy prisons approach to health promotion and health improvement, the role of the health care team, working in partnership with others, may be expanded. For example, the health care team manager may well act as a co-ordinator, ensuring that comprehensive and efficient health promotion programmes and activities are delivered, as well as providing strategic direction and policy making, in order to deliver the healthy prisons approach.

7.5 Liaison with external agencies

A significant amount of the nurses' time is spent liaising with external agencies. As a general rule of thumb the more senior the grade of nurse the greater the amount of time is spent on this activity. There are two key groups that were identified as having to have regular professional contact with:

- internal to the prison but outside the health care unit
- external health and social care providers external.

Nurses stated that to operate efficiently and successfully health care staff needed a good working relationship with other prison staff and in particular with the prison officers. Nurses felt that they often had to earn the prison officers respect and were often viewed with some scepticism. The Northern Ireland prison nurses felt that by training alongside prison officers for at least some of the time and having the same operational rights as other prison officers had helped considerably in gaining greater acceptance. Some nurses had clearly gone to great lengths to help prison colleagues to understand their roles and the function of the service. Liaison with prison colleagues needs time and regular daily attention to ensure that health care provision to prisoners is maintained outside the formal setting of the health centre.

Liaison with external services is varied and includes:

- GP's
- accident and emergency departments
- local hospital wards where prisoners are in-patients,
- psychiatric units and individual psychiatrists
- dentists
- psychologists
- physiotherapists
- social services
- individual social workers.

Clearly this list is not intended to be exhaustive but demonstrates the range of contacts that nurses are required to maintain to ensure effective health care to their prisoner/patients. This aspect of the role requires significant inter-personal skills, confidence and assertion to perform effectively.

7.6 Reception and screening

Every day prisons receive prisoners from the courts who have been remanded, convicted and sentenced, or who waiting to be sentenced. Included in the number of reception prisoners there are 'new to this prison' arrivals who have been transferred from other prisons for a variety of reasons, but who will already have received a health care assessment. In practice nearly all prisoner deliveries occur in the late afternoon or early evening, and this results in too few health care staff to prisoners, and it also leads to time pressures on staff processing assessments.

Large numbers of prisoners arriving at once makes it difficult to respond appropriately. Reception is also a time of high anxiety for prisoners and there is often a heightened risk of self-harm and suicide. Clearly missing the signs and symptoms of people presenting with these problems at reception can have the most serious of consequences. Ways of reducing the risk by using more accurate assessment material and ensuring that all known information on those prisoners likely to be at risk in first hours/days in prison should be considered.

Following the initial reception screening, opportunities should be provided for a more comprehensive health check without the same time constraints and pressures of the initial reception. Thought should be given to the content and format for such an examination, which should include a mental health assessment, and the competencies required for the nurse to undertake this task.

Any specific problems identified from the health assessment can be referred to a medical officer or specialist nurse. Comprehensive care plans based on individual needs assessments should also be developed for the prison setting.

7.7 Emergency nursing and crisis care

If a health crisis of any type is identified in the prison the usual first contact is with health care centre's nursing staff. Emergencies can vary from various physical injuries (in particular a high level of sports injuries and injuries sustained through fighting) through to serious psychiatric crisis of self-injury or suicide attempts. The nurse must be in a position to be able to respond quickly to these emergencies or to assess whether they require more intensive treatment and care from external health services. These situations are stressful for the nurses to deal with and place a great deal of responsibility on them to make quick and effective decisions.

Nurses are helped in this process by having the facility to admit patients directly to the health centres where beds are available. But they are sometimes frustrated by being unable to discharge patients to facilitate this process because as all discharge decisions are taken by medical staff.

To perform this task nurses require a high level of technical expertise in dealing with accident and emergency situations, and also high levels of communication skills to ensure the patients accesses the right services. In some cases, for example, prison staff may be reluctant to transfer a prisoner to hospital for security reasons.

7.8 The Chief Nursing Officer for England and Wales ten key roles

In his speech to the RCN Congress 2000, the Secretary of State for Health Alan Milburn highlighted improvements brought about by nurses who had expanded their roles. He cited 10 roles that nurses were doing in some parts of the NHS but not in others, and he challenged the health service to ensure that nurses to carry out these clinical practices in every part of the NHS.

This was restated in the *NHS plan* as the Chief Nursing Officer's (CNO) 10 key roles for nurses. It was placed in the context of the Government's commitment to break down barriers between staff and to shatter the old demarcations that have held staff back and slowed down health care improvements. (Department of Health, 2000).

The *NHS plan* makes it clear that NHS employers are required to empower appropriately qualified nurses to undertake a wider range of clinical tasks. These include the right to:

- receive referrals
- admit and discharge patients
- order investigations and diagnostic tests
- run clinics
- prescribe drugs.

The NHS Plan Implementation Programme makes it clear that during 2001/2002 NHS employers must ensure that they plan, develop and implement new and innovative roles to help reshape and improve services, and that health communities are responsible for taking full advantage of new flexibility in the workforce. Health communities, including associated universities, need to ensure that every opportunity is taken to prepare and empower nurses, midwives and therapists to undertake expanded and new roles where it improves access, quality or services and benefits patient care.

If the prison service aims to ensure that it keeps in step with the NHS then it needs to embrace such concepts and develop nursing practice accordingly.

Table 36 represents an attempt to consider how current nursing practice in prison health centres already matches the CNO's key roles, followed by some consideration in how these might be developed in the future.

CNO's KEY ROLES	The Application to prison nursing
1. To order diagnostic tests such as pathology tests & x rays	• Drug Screening • Alcohol meter • Clozaril clinics • Lithium monitoring • Psychological assessment • Routine bloods • X Rays
2. To make & receive referrals direct, eg to a therapist or pain consultant	• To receive referrals from prison officers and other health care colleagues for assessment and specialist nursing advice • To refer on for psychology/psychotherapy assessment & follow up occupational therapy assessment • Assessment for psychotherapy • Refer on for specialist medical care
3. To admit & discharge patients for specified conditions within agreed protocols	• To access acute and respite care through nurse managed beds • To admit prisoners directly from reception/screening where the nurse had identified a health need
4. To manage patient caseloads, eg diabetes or rheumatology	• Asthma caseloads • Diabetes caseloads • Substance misuse caseloads • Anxiety, phobia and stress-related caseloads • Psychosis caseloads
5. To run clinics, e.g. ophthalmology or rheumatology	• Primary Care assessment & counselling clinics • Substance Misuse • Primary care; daily dispensing clinics • Asthma clinics • Diabetes clinics
6. To prescribe medicines and treatments	• Emergency prescriptions within agreed protocols; dosage adjustments • Monitoring side effects • Encouraging understanding & compliance through education in a variety of settings, including: substance misuse services • Determine levels of enhanced nursing observation for at risk patients • Prescribe from an agreed formulary
7. To carry out a wide range of resuscitation procedures including defibrillation	• Suicide prevention through risk assessment, effective engagement, • Responsive care planning including crisis & contingency plans • Life saving interventions in self-harm • Harm reduction in substance misuse • Defibrillation • To offer CPR support to the wider prison

Table 36: The CNO's ten key roles and their application to prison nursing

CNO's KEY ROLES	The Application to prison nursing
8. To perform minor surgery	• Suturing • Dressings • Ear syringing • Eye irrigation • Venepuncture • Lancing • Catheterisation
9. To triage patients using the latest IT to the most appropriate health professional	• Ensure effective documentation regarding decision-making, care & treatment, and the ethical and practical sharing of information with other agencies. • Primary care • Reception and screening • Prison community care
10. To take the lead in the way local health services are organised and in the way in which they run	• To positively influence local developments, promoting inclusive practices and strategies • User groups • Multi-agency stake holders • Training & education • Commissioning and delivery

Table 36 (continued): The CNO's ten key roles and their application to prison nursing

As can be seen from Table 36 the role of the prison nurse already embraces many of the elements that are seen to be innovative and contemporary for nursing practice. As the Secretary of State said of the NHS, the challenge is in how this is made more universally available throughout the service and how it becomes the norm rather than the exception.

The 10 key roles proposed by the CNO offer an opportunity to consider how advanced practice might be developed in the service and how this might be reflected in a clinical career structure, which the data from this study highlighted was sadly lacking.

7.9 Boundaries of practice

Data suggests that two aspects of boundaries are of relevance. The first concerns the boundaries of practice in nursing between the various grades of nurses and the tasks they are called on to undertake. It was clear that nurses in health centre one services were asked to perform a wider range of tasks, reporting higher levels of both supervisory activity as well as performing the tasks themselves. This finding could have been expected because fewer nurses are employed in this type of centre. Therefore, nurses would be asked to fulfil the complete span of tasks from work that might ordinarily have been completed by a more junior grade, as well as higher level supervisory and skilled nursing practices.

It was evident from the case study and focus group data that some sub-specialism exists, particularly among the larger nursing teams in health centre three services. Often staff were rotated through various teams and activities but there was preference given to try to match skills to activities. An example of this was found in the reception and screening of prisoners where staff with a dual RGN/RMN qualification were asked to assess prisoners. Centres also had nursing staff who focused exclusively on drug abuse and mental health issues. Other staff had taken on additional specialist activity such as asthma care and ran clinics each week alongside their role as a general part of the nursing team.

Inevitably balances need to be found between what all nursing staff need skills in and what is identified as a specialised activity. Circumstances will clearly differ between the services, but the concept of a higher level of specialism built on a general competency base appears to be the model that most suits the needs of health centre three services. In health centres one and two, the need for specialist staff and skills appeared less marked but did require individuals who had a broad range of knowledge and skills and an ability to be flexible and autonomous in practice.

The other key area of boundaries of practice exists between the professional groups, and in particular between nursing and medical staff. There is clearly the need for strong alliances between the professional groups as each depends on the other in terms of safety in practice. Nurses appeared to perform a high level of triage activity in all health centres. This involved reception and screening, outpatients and prison community work. This is a highly skilled and responsible area of practice and it was not clear whether nurses had received sufficient training and development in order to fulfil this role. It is possible that more could be made available to support them in this task. For example, diagnostic protocols.

There was wide spread support for the wider introduction of nurse prescribing. This is currently limited to over-the-counter preparations and many nurses felt that this could usefully be extended to include an agreed formulary of prescribed medication. Nurses felt that it would save them time and provide better care to the prisoner. Any drugs that were known to be addictive or that could be used for trading purposes would be specifically excluded from the formulary. Some nurses did acknowledge that they might be subjected to intense pressure from some prisoners if it was known that they could prescribe certain drugs, and as they had a more regular and intense relationship with the prisoners than doctors it could be particularly difficult. However, drugs such as antibiotics could easily be extended to nurses for prescribing purposes, which do not run these risks. As this area of practice is currently the domain of the medical staff it could meet with some resistance but it should not prohibit examination of the possibilities.

- Other areas of boundary overlap concerns issues such as nursing involvement in:

- minor surgery
- resuscitation
- running clinics
- managing caseloads
- the admission and discharge of patients
- making direct referrals to a therapist or consultant
- ordering diagnostic tests.

Clearly these activities suggest higher levels of practice, and it was disappointing to find that little higher level practice appeared evident from the respondents. A radical view might be that this is an area of nursing activity where a health centre could be totally nurse-run within agreed protocols. Given the difficulties with recruitment and retention of all professional groups over the years it could be regarded as surprising that this has not already been proposed and the feasibility explored. Generally, however, prisons and their management tend to be conservative institutions not renowned for innovation in practice.

If nursing continues to develop in prison health centres then it is inevitable that some frictions will arise between some of the traditional professional groups as a status quo is challenged. What will need to remain at the focus of consideration is the health, safety and welfare of the prisoners and the care services.

7.10 End thoughts

Significant developments that will influence nursing care in prisons are due to come to fruition during 2001. As well as this study there are the custodial health care occupational standards currently in draft form, which will provide a detailed and extensive framework for the training and development of nursing practice in this speciality. Also the World Health Organisation guidance on primary mental health care for prisons is nearing completion. This will provide a ready resource of contemporary information for non-specialists for this area of practice.

The challenge will be in how these significant contributions to the development of practice are embraced and driven forward for the service. Some strategic thinking is needed on how these various strands can be brought together and made to happen, taking in account their impact on the service and consequently the prisoners that they are providing care for.

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Annexe 1: Competencies - Importance

No.	Competency		Unimportant (%)	Undecided (%)	Important (%)
Q1	Promote people's equality, diversity and rights	1	3.6		96.4
		2	4.7	1.6	93.8
		3	8.0	3.9	88.1
Q2	Promote effective communication and relationships	1	3.6		96.4
		2	3.1	1.5	95.4
		3	7.4	0.6	92.0
Q3	Promote communication with individuals where there are communication differences	1	3.4		96.6
		2	3.1	1.5	95.4
		3	6.6	1.8	91.6
Q12	Enable individuals to develop meaningful relationships with others	1	4.2	16.7	79.2
		2	7.5	7.5	84.9
		3	6.8	12.3	80.8
Q24	Build and sustain relationships with individuals to reinforce their therapeutic goals	1	4.0	16.0	80.0
		2	6.0	4.0	90.0
		3	4.6	5.9	89.5
Q26	Support individuals with difficult or potentially difficult relationships	1	3.8	11.5	84.6
		2	1.8	7.3	90.9
		3	4.7	7.5	87.8

Table 37: Theme 1 Communication and relationships

No.	Competency		Unimportant (%)	Undecided (%)	Important (%)
Q4	Assess individuals to determine their overall needs and risk	1	3.7		96.3
		2	4.8		95.2
		3	7.4	0.3	92.3
Q5	Provide specialist assessment services on individuals' needs so that others can take action	1	3.8	3.8	92.3
		2	4.7	3.1	92.2
		3	5.0	5.0	90.0
Q6	Assist in the assessment of, and the planning of programmes of care for, individuals	1	3.4		96.6
		2	4.8	1.6	93.7
		3	7.2	1.8	91.0

Table 38: Theme 2 Assessment

No.	Competency		Unimportant (%)	Undecided (%)	Important (%)
Q7	Plan specific therapeutic interventions to enable individuals to recognise and address any socially unacceptable behaviour	1	4.8	9.5	85.7
		2	8.6	13.8	77.6
		3	6.6	5.6	87.8
Q8	Contribute to the joint implementation and monitoring of programmes of care for individuals	1	3.8	7.7	88.5
		2	6.3	3.2	90.5
		3	5.1	3.3	91.6
Q9	Implement specific therapeutic interventions to enable individuals to manage their behaviour	1	4.5	13.6	81.8
		2	5.1	6.8	88.1
		3	5.1	5.8	89.1
Q10	Assist in the implementation and monitoring of specific therapeutic interventions	1	4.2	12.5	83.3
		2	5.3	3.5	91.2
		3	4.7	6.9	88.4
Q14	Contribute to the evaluation and improvement of programmes of care for individuals	1	4.0	8.0	88.0
		2	1.7	1.7	96.7
		3	5.1	2.4	92.5

Table 39: Theme 3 care Planning, Implementation and Evaluation

No.	Competency		Unimportant (%)	Undecided (%)	Important (%)
Q15	Assess individuals' needs for primary health care services	1	3.6	3.6	92.9
		2	4.8	1.6	93.7
		3	5.6	5.0	89.4
Q16	Develop, monitor and review programmes of primary health care for individuals	1	3.8	3.8	92.3
		2	3.2	1.6	95.2
		3	5.9	7.1	87.0
Q17	Contribute to raising awareness of health issues	1	3.6		96.4
		2	3.2	3.2	93.5
		3	4.8	2.7	92.5
Q18	Enable individuals to address issues which affect their health and wellbeing	1	3.6		96.4
		2	3.1	1.6	95.3
		3	5.4	1.8	92.8

Table 40: Theme 4 Health and primary Health Care

No.	Competency		Unimportant (%)	Undecided (%)	Important (%)
Q19	Raise awareness of the needs of individuals discharged from your services	1	3.8	11.5	84.6
		2	1.7	8.3	90.0
		3	6.4	8.7	84.9
Q20	Promote the needs of individuals in the community	1	10.0	20.0	70.0
		2	4.2	12.5	83.3
		3	10.7	17.4	71.9
Q21	Negotiate, agree and support placements for individuals	1	9.1	13.6	77.3
		2	2.2	21.7	76.1
		3	9.9	17.9	72.2
Q22	Develop, monitor and review discharge packages to manage individuals	1	8.3	16.7	75.0
		2		18.4	81.6
		3	9.8	12.7	77.5

Table 41: Theme 5 Discharge and Community Support

No.	Competency		Unimportant (%)	Undecided (%)	Important (%)
Q11	Enable individuals to develop and maintain skills of independent living	1	4.0	4.0	92.0
		2	3.5	10.5	86.0
		3	6.0	8.5	85.5
Q13	Enable individuals who are at risk to themselves and others to identify behavioural boundaries and develop control	1	4.2	12.5	83.3
		2	3.4	3.4	93.2
		3	5.5	2.1	92.4
Q23	Contribute to the provision of effective physical, social and emotional environments for group care	1	4.3	13.0	82.6
		2	6.1	10.2	83.7
		3	6.7	10.4	82.9
Q31	Contribute to establishing and running mutual support networks	1	9.1	13.6	77.3
		2	4.4	6.7	88.9
		3	12.6	18.1	69.3
Q32	Support individuals when they are distressed	1	3.6	3.6	92.9
		2	3.3	3.3	93.4
		3	5.7	0.6	93.7

Table 42: Theme 6 Providing and Developing Therapeutic Environments

No.	Competency		Unimportant (%)	Undecided (%)	Important (%)
Q25	Physically intervene in situations where there is a breakdown in environments and relationships to limit risks to those involved	1	4.8	19.0	76.2
		2	3.8	19.2	76.9
		3	5.5	9.6	84.9
Q33	Create and maintain boundaries between the community and individuals detained in secure conditions	1	4.8	19.0	76.2
		2	2.4	9.8	87.8
		3	11.9	13.8	74.3
Q34	Protect patients from themselves and each other	1	4.2		95.8
		2	3.6	3.6	92.7
		3	5.5	3.3	91.2
Q35	Contribute to the protection of individuals from abuse	1	4.2	4.2	91.7
		2	3.6		96.4
		3	4.9	2.4	92.7
Q36	Escort patients within and beyond secure settings	1	10.5	26.3	63.2
		2	2.1	23.4	74.5
		3	12.8	10.0	77.2

Table 43: Theme 7 Safety

No.	Competency		Unimportant (%)	Undecided (%)	Important (%)
Q27	Enable individuals to maintain contacts in isolating situations	1	7.7	15.4	76.9
		2	1.9	7.7	90.4
		3	6.5	10.0	83.5
Q28	Enable individuals to adjust to and manage their loss	1	3.7	11.1	85.2
		2	1.9	5.6	92.6
		3	5.4	7.0	87.5
Q29	Enable individuals' partners, relatives and friends to adjust to and manage the individual's loss	1	10.0	35.0	55.0
		2	2.6	26.3	71.1
		3	12.3	22.3	65.4
Q30	Enable individuals, their partners, relatives and friends to explore and manage change	1	5.6	16.7	77.8
		2	2.6	23.7	73.7
		3	10.9	23.2	65.9

Table 44: Theme 8 Helping Manage Change and Loss

No.	Competency		Unimportant (%)	Undecided (%)	Important (%)
Q38	Support and lead teams to enable work objectives to be met	1	4.3	8.7	87.0
		2	2.0	4.0	94.0
		3	4.9	10.2	84.9
Q39	Support staff in maintaining their identity and safe personal boundaries	1	4.2		95.8
		2	1.9	1.9	96.2
		3	4.3	3.6	92.1
Q40	Counsel and support staff in times of stress	1	4.0		96.0
		2	1.9		98.1
		3	5.1	3.9	91.0

Table 45: Theme 9 Staff Support

No.	Competency		Unimportant (%)	Undecided (%)	Important (%)
Q43	Contribute to the development of knowledge and practice	1	3.4		96.6
		2	3.3	1.7	95.0
		3	4.5	2.7	92.8
Q44	Develop oneself within the role	1	3.4		96.6
		2	4.9		95.1
		3	4.8	1.2	94.0
Q45	Contribute to the development of others	1	3.4	3.4	93.1
		2	4.9	1.6	93.4
		3	4.6	3.0	92.4

Table 46: Theme 10 Professional Development

No.	Competency		Unimportant (%)	Undecided (%)	Important (%)
Q37	Manage one's caseload against the prioritised needs of individuals	1	4.0	4.0	92.0
		2	5.5	5.5	89.1
		3	7.1	11.0	81.8
Q41	Promote, monitor and maintain health, safety and security in the workplace	1	3.6		96.4
		2	3.3	1.7	95.0
		3	4.2	2.4	93.4
Q42	Receive, transmit and store information	1	3.4		96.6
		2	5.0	1.7	93.3
		3	4.5	3.0	92.5

Table 47: Theme 11 Management

Annexe 2: Audit results

		AUDIT	
ITEM	**STANDARD**	**Yes**	**No**
1.1	The grade mix of staff is related to the needs of the patients.	7	2
1.2	The experience of staff is taken into account.	9	
1.3	Staff are able to determine the difference between physical security & relational security	9	
1.4	Flexible staffing systems are arranged around the needs of the patient.	6	2
1.5	All wards have appropriate resources to minimise/intervene in episodes of violence or dangerous behaviour.	7	
1.6	All staff are familiar with security policies and take personal responsibility for security issues.	9	
1.7	Each registered nurse has access to their specific job description	6	3
1.8	A copy of current nursing job descriptions are available on the ward/dept for reference	2	7
1.9	The ward/dept has undergone a skill/grade mix review in the last 3 years	6	3
1.10	There are sufficient qualified nurses to meet the provision of care in line with the nursing objectives	7	2
1.11	The ward can claim adequate supervision of novices and students by:		
1.11.1	At least one nurse is trained in clinical supervision techniques	4	5
1.11.2	At least one nurse is trained in Teaching and Assessing techniques	6	3
1.11.3	At least one nurse is a trained preceptor	2	7
1.12	Recruitment procedures are consistent with equal opportunities legislation	9	
1.13	Nurses have a clear line of managerial accountability	9	

Table 48: Competencies required of nurses in secure settings

		AUDIT	
ITEM	**STANDARD**	**Yes**	**No**
2.1	A resource file of pertinent research papers to the area of clinical practice is kept on the ward	6	3
2.2	The resource file is varied and up to current date	5	4
2.3	Research papers are disseminated to ward level and are stored for reference and are easily accessible	6	3
2.4	Nurses have demonstrated a need for change through research	8	1
2.5	Nursing policies and procedures reflect current knowledge, research findings and principles of nursing practice with all reference sources demonstrated	7	2

Table 49: Are nursing interventions evidence-based?

		AUDIT	
ITEM	**STANDARD**	**Yes**	**No**
3.1	At least one member of the ward team has been instructed in Standard Setting and acts as a resource to the ward team	7	2
3.2	Standards are audited by the ward team at least twice a year and necessary changes implemented.	3	6
3.3	Standards are reviewed every 12 months by the ward team.	5	4
3.4	Ward staff are aware of the standards of care.	9	
3.5	Ward standards are displayed for patients' information.	4	5
3.6	Each ward has a nursing policies and procedures file	8	1
3.7	Staff are satisfied with their level of involvement in the development of policies and procedures	5	4
3.8	Local policies and procedures are consistent with legislation affecting nursing practice and current professional guidelines	8	1
3.9	Each new patient has a written assessment carried out by a registered nurse within an agreed time-scale	8	1
3.10	Each patient and family has access to a named nurse	6	3
3.11	Nurses receive clear written operational guidance which is regularly reviewed and includes:	6	3
3.11.1	The nurses role, function and contribution to the assessment process, including risk assessment, care planning and discharge arrangements for patients	8	1
3.11.2	Arrangements to meet responsibilities arising from relevant legislation and guidance	9	
3.11.3	Equal opportunities strategy	9	
3.11.4	The protection of patients rights	9	
3.11.5	The nurse's contribution to treatment	9	
3.11.6	Safety and security aspects	9	
3.11.7	Record keeping, access to records and confidentiality	9	
3.12	Systems are in place to monitor the cost, efficiency and effectiveness of nursing in meeting its objectives and priorities	9	

Table 50: The development of practice standards

		AUDIT	
ITEM	**STANDARD**	**Yes**	**No**
4.1	All ward-based staff have undergone an induction course organised by their new employers.	5	4
4.2	All staff have undergone a ward-based induction.	7	2
4.3	Newly appointed nurses have received an information pack (reviewed every 3 years) with the following information;	8	1
4.3.1	Details of post and job description	6	3
4.3.2	The line of accountability	9	
4.3.3	The qualifications required and grade of the post	9	
4.3.4	The functions and responsibilities of the post (including Quality issues)	9	
4.3.5	The frequency of Individual performance review	9	
4.3.6	The terms and conditions of service	9	
4.3.7	The profile of the ward/dept initially posted to	8	1
4.4	New employees receive a mandatory period of 2 weeks supernumerary induction	5	4
4.5	Newly employed but qualified nurses not having worked in the last 5 years attend a mandatory return to practice course	*	*
4.6	Newly qualified nurses attend and complete workshops and portfolio work for the preceptorship programme	*	*
4.7	Novices involved in preceptorship receive regular clinical supervision from the named preceptor at least fortnightly	*	1*
4.8	Each nurse has a named clinical supervisor	1	8
4.9	Nurses take part in some form of clinical supervision at least once a month		9
4.9.1	Nurses take part in some form of clinical supervision at least once every 3 months on request	4	5
4.10	The ward induction booklet/profile contains evidence supporting:		
4.10.1	The profile of the ward/dept	9	
4.10.2	The nursing philosophy	9	
4.10.3	Induction materials and checklists	7	2
4.11	There exists a staff development programme which includes requirements for continuing training, links with forensic and other nursing outside the unit and other opportunities for professional growth	8	1
4.12	The training programme includes:		
4.12.1	Issues in relation to gender, sexual orientation, race and culture, religion, language, age and ability	8	1
4.12.2	The assessment of risk and dangerousness	8	1
4.12.3	Safe practice guidelines	9	
4.12.4	Mental health legislation and guidance	5	4
4.12.5	The drawing up of an annual training programme for each nurse	6	2
4.12.6	Care and responsibility	6	2
4.12.7	De-escalation techniques	5	4

*** Many of the organisations had not employed newly qualified or returners to practice.**

Table 51: The preparation given to nurses

		AUDIT	
ITEM	**STANDARD**	**Yes**	**No**
5.1	Staff integrate with patients whilst being aware of security needs.	9	
5.2	There is a policy on the handling of violent incidents.	7	2
5.3	Staff are aware of the policy for handling violent incidents	7	2
5.4	Members of the ward team have attended a Control & Restraint course	6	2
5.5	Nurses have knowledge of the patients within the ward and are able to minimise patients disturbed behaviour.	9	
5.6	The ward has an identified seclusion procedure	4	4*
5.7	Nurses are aware of the seclusion policy.	5	3*
5.8	There is a post-incident discussion with the patient.	4	3*
5.9	The rights of detained patients are ensured under the provision of the 1983 Mental Health Act	3	2
5.10	Individual safety and security needs are reviewed to meet the changing needs of the patient	9	
5.11	Individual safety and security needs are clearly written within the treatment plan	8	
5.12	The ward has an identified procedure for Special Observation	5	1*
5.13	Staff de-briefing is available following a serious incident	9	
5.14	Members of the ward team have received instruction on use of de-escalation techniques	6	3

*** Some Health Care Centres within the Prison Service do not have in-patients, therefore seclusion and observation procedures are not appropriate.**

Table 52: Working with difficult patients

		AUDIT	
ITEM	**STANDARD**	**Yes**	**No**
6.1	Copies of all leading UKCC and Professional documents are held on the ward for easy reference	3	1
6.2	Code of Professional Conduct	9	
6.3	Guidelines for Record Keeping	3	5
6.4	Guidelines regarding Accountability	6	2
6.5	Scope of Professional Practice	8	1
6.6	Guidelines for mental Health and Learning Disability Nursing	5	4
6.7	PREP guidelines	7	2
6.8	Making a Complaint	7	1
6.9	Guidelines regarding Confidentiality	4	3
6.10	Standards for Administering Medicines	7	2
6.10.1	There is a procedure for safe custody, prescribing and administration of drugs.	8	1
6.10.2	Drug keys are kept in the appropriate secure place	9	
6.10.3	Staff are aware of the safe keeping of drugs	9	
6.10.4	Drugs are stored in accordance with the medicine procedures	8	1
6.10.5	A record of errors is kept and is available for reference	1	6
6.10.6	The record of errors book demonstrates the investigation of the cause of error and the outcome, identifying actions taken to avoid re-occurrence	1	6
6.10.7	Prescriptions are clearly written ,typed or computer generated and entries are indelible and dated	8	1
6.10.8	Where a new prescription replaces earlier prescriptions the latter have been cancelled clearly and the cancellation signed and dated by an authorised medical practitioner	6	3
6.10.9	The prescription provides clear and unequivocal identification of the patient for whom the medicine is intended	7	2
6.10.10	There is a clear procedure for identification of the patient	5	4
6.10.11	The substance to be administered is clearly specified	9	
6.10.12	The form has been clearly stated (e.g. tablet, syrup etc.)	9	
6.10.13	The administration of un-prescribed medicines is covered by a recognised protocol agreed between managers, nurses, pharmacists and medical practitioners	8	1
6.11	The nurse in charge of the ward/unit is able to satisfy themselves that all registered nurses in their charge are	6	
6.11.1	Knowledgeable and understanding of the substances used for therapeutic purposes	9	
6.11.2	Able to justify any actions they take	9	
6.11.3	Prepared to be accountable for any actions they take	9	
6.11.4	Knowledgeable regarding the identity of patients	9	
6.11.5	Aware of the patients current assessment and planned programme of care	8	
6.11.6	Pay due regard to the environment in which care is given	9	
6.11.7	Carefully scrutinise the written prescription and the information provided on relevant containers	9	
6.11.8	Able to question and challenge the medical practitioner or pharmacist if the prescription or container is illegible, unclear, ambiguous or incomplete or falls outside the product licence and where believed necessary to refuse to administer a prescribed substance	9	
6.11.9	Refuse to prepare substances for injection in advance of their immediate use	9	
6.11.10	Refuse to administer a medicine not placed in a container or drawn into a syringe by them or in their presence	9	

Table 53: Utilising UKCC policies to inform practice (1)

		AUDIT	
ITEM	**STANDARD**	**Yes**	**No**
6.12	The ward displays a range of patient information leaflets concerning their prescribed medicines	1	8
6.13	The nurse in charge of the ward is able to satisfy themselves of the competency of each registered nurse to:	1	
6.13.1	Check the expiry date of any medicine	9	
6.13.2	Carefully consider the dosage, method of administration, route and timing of administration in the context of the specific patient at the operative time	9	
6.13.3	Carefully consider whether any of the prescribed medicines may dangerously interact with each other	9	
6.13.4	Determine whether it is necessary to withhold a medicine pending consultation with the prescribing medical practitioner	9	
6.13.5	Contact the prescriber without delay where the contra-indications of the medicine are observed	9	
6.13.6	Make clear and accurate records of the administration of all medicines administered or deliberately withheld	9	
6.13.7	Where a medicine is refused by a patient assess the consequences and inform the prescriber accordingly	8	
6.13.8	Use the opportunity which administration of medicine provides for emphasising to patients and carers the importance and implications of the prescribed treatment and for enhancing their understanding of its effects and side effects	7	1
6.13.9	Make accurate records of the positive and negative effects of the medicine, making these known to the prescribing medical practitioner	7	1
6.13.10	Honestly acknowledge personal limitations and seek further advice whenever this is felt to be necessary	8	

Table 54: Utilising UKCC policies to inform practice (2)

		AUDIT	
ITEM	**STANDARD**	**Yes**	**No**
7.1	Interpretation services are available if required.	6	2
7.2	Nurses are aware of patients with hearing loss and can respond to communication.	8	
7.3	Nurses are aware of patients who have difficulties with verbal communication and can respond accordingly	9	
7.4	All patients receive nursing care and treatment that is designed to meet each individuals needs in an appropriate and non-discriminatory manner.	9	
7.5	Records indicate that additional support is provided where appropriate e.g. chiropodist, Dietician, Optician, Speech Therapist	8	
7.6	Specific advice and/or clinics are provided on issues such as asthma and diabetes	7	2
7.7	Patients are given the opportunity to access fresh air and exercise	9	
7.8	There is an identified Health Promotion nurse	5	4
7.9	Patients are offered a monthly health check at ward level (including blood pressure, urine analysis, pulse and weight) any problems highlighted are referred to the G.P	1	8
7.10	Patients are offered an annual dental check up	5	4
7.11	In the event of physical ill-health, patients have access to a G.P	8	1
7.12	Where necessary patients are transferred to a local acute NHS Trust for more specialised treatment	9	
7.13	Patients have the right to request a second opinion about any aspect of their physical treatment	9	
7.14	Patients who require a particular type of diet to suit their religious/cultural/dietary needs are provided with them	8	1
7.15	Patients can expect information to be in plain language and, where necessary, in languages other than English and in forms which people with sight, hearing , learning or other disabilities can use	9	
7.16	If patients have problems with hearing or speech, or their first language is not English, they can expect help in getting access to services, including where appropriate, interpreting services	9	
7.17	People have a choice in being treated by a health professional of their own gender	8	1
7.18	The patients preferences are documented in the care plan and the individuals spiritual and cultural needs are taken into consideration with details noted	8	
7.19	Nurses demonstrate awareness of, and sensitivity to the issues associated with gender, sexual orientation, race and culture, religion, language, age and ability	9	

Table 55: Practice issues relevant to physical health needs